

Medical Assessment Form

Unaccompanied Alien Children Bureau Office of Refugee Resettlement (ORR)

General Information

Child	Last name:			First name:		
	DOB:		A#:		Sex:	Date evaluated:
	Time evaluated:					
	Primary language:		Who provided appropriate language services for child during evaluation?		☐ HCP fluent in child's primary language ☐ Trained interpreter ☐ Not provided	
Evaluating Healthcare Provider (HCP)	Name:			Phone number:		Clinic or Practice:
	MD / DO / PA / NP					
	Street address:		City/Town:		State:	
	Location where child received care (e.g., Primary health care provider/Pediatrician, medical specialist):					
Program	Program name:				☐ Program Staff Member Present During Exam with HCP	
Reason for visit:	☐ Initial medical exam (IME)* ☐ Specialist visit, type: _____ ☐ New complaint/concern ☐ Routine well-child check/Establish care ☐ Follow-up visit with PCP for previous complaint/concern					

History and Assessment*

Vital Signs

Temperature (T)	Heart Rate (HR)	BP (≥ 3 yrs)	Resp Rate (RR)	Height (HT)	Weight (WT)	BMI (≥2 yrs)	BMI %ile
°C				cm	kg		

Allergies: ☐ No ☐ Yes, specify below:

	Food	Medication	Environmental
Allergen			
Reaction			

Vision Screening (≥ 3 years): ☐ Yes, specify below ☐ Not performed **Hearing Screening:** ☐ Yes, specify below ☐ Not performed

	Right Eye	Left Eye	Both eyes	Final		Pass	Fail
Corrected	20 /	20 /	20 /	☐ Pass ☐ Fail	OAE/ABR (Preferred for < 4 years)	☐ Pass	☐ Fail
Uncorrected	20 /	20 /	20 /	☐ Pass ☐ Fail	Pure Tone Audiometry (Preferred for ≥ 4 years)	☐ Pass	☐ Fail
					Gross Hearing (Acceptable for all ages)	☐ Pass	☐ Fail

Medical & Mental Health History (including dates & locations of care)

Surgeries: _____

Hospitalizations: _____

Chronic/Underlying conditions: _____

Family: _____

Healthcare received in DHS custody/during journey: _____

Medications (dosage frequency & dates): ☐ Past: _____
☐ Current: _____

Reproductive History (complete for anatomically female UC who have started menarche):

Date of LMP: ____ / ____ / ____, ☐ Approximate ☐ Exact ☐ Contraceptive use, specify (e.g., IUD, pills): _____

Pregnancy history: ☐ No ☐ Yes, # of: vaginal deliveries ____, C-sections ____, miscarriages/abortions ____, ectopics ____, living children ____

Pregnancy/Postpartum complications: _____ ☐ Currently breastfeeding

History of abuse: ☐ Yes, specify ☐ Denied, with no obvious signs ☐ Denied, but obvious signs present ☐ Unknown

Type(s): ☐ Verbal ☐ Emotional ☐ Physical, specify: _____

☐ Sexual (with or without penetration), estimated date of last encounter: ____ / ____ / ____

☐ Other victimization (e.g., gang, bullying, crime): _____

Consensual sexual activity (with penetration): ☐ No ☐ Yes, estimated date of last encounter: ____ / ____ / ____ ☐ Unknown

Substance use: ☐ Yes, specify ☐ Denied, with no obvious signs/symptoms ☐ Denied, but obvious signs/symptoms present ☐ Unknown

	Alcohol	Tobacco/Nicotine	Marijuana	Injection drugs (IDU)	Other substances
Specify substance(s)			N/A		
Frequency/Quantity					
Date of last use					

Travel history: _____

Review of Systems (ROS) and Physical Exam*

Concerns expressed by child/caregiver: ☐ No ☐ Yes, specify: _____

Were any physical signs/symptoms reported by the child or observed by program staff or HCP?

€ No € Yes, check all applicable signs/symptoms and enter the onset date (mm/dd/yyyy):

Sign/Symptom	• Pain, location: _____	€ Fever (>37.8 C°) or chills	€ Red Eyes	€ Runny Nose	€ Sore Throat	€ Cough	€ Difficulty breathing/Shortness of Breath
Onset Date							
Sign/Symptom	€ Nausea	€ Vomiting	€ Diarrhea	€ Neck stiffness	• Headache	€ Dizziness	€ Confusion/Altered mental status
Onset Date							
Sign/Symptom	€ Neurologic symptoms	€ Skin lesions/Rash	€ Yellow skin/eyes	€ Swollen glands	€ Unusual bleeding	€ Other:	€ Other:
Onset Date							

Physical Examination*

Systems	Normal findings	Abnormal findings, specify or if not evaluated, give reason:
General	• Well-appearing/nourished; no distress; developmentally appropriate	•
Head/Neck	• Normocephalic, neck supple; no adenopathy or masses	•
Eyes	• PERRL, EOMI; no redness/discharge	•
ENT/Dental	• TMs WNL; no rhinorrhea; o/p w/o erythema, lesions, caries, abscess	•
Cardiovascular	• Regular rate & rhythm; no murmurs; normal pulses; cap refill < 3 sec	•
Lungs	• Clear to auscultation, no wheezes, crackles, rhonchi, no accessory muscle use	•
Abdomen	• Non-distended; soft and non-tender; no masses or organomegaly	•
Genitourinary	• External GU normal; Tanner ____: no lesions, discharge, hernia	•
Musculoskeletal/Back/Extremities	• Full range of motion of all extremities; no joint swelling, erythema; no scoliosis	•
Neurologic	• Typical gait, strength, tone, sensation, speech & behavior for age	•
Skin	• No rashes, lesions, jaundice, pallor, scars, birthmarks, or tattoos	•

Other:

Were any mental health signs/symptoms reported by the child or observed by program staff or HCP?

• No • Yes, specify below:

- Feels empty, hopeless, sad, numb more often than not
- Feels constantly worried, anxious, nervous more often than not
- Experiences mood swings, from very high to very low
- Relives traumatic events from the past
- Feels easily annoyed or irritated
- Feels afraid, easily startled, jumpy
- Has trouble concentrating, restless, too many thoughts
- Has trouble eating, sleeping
- Has nightmares
- Engages in self-harm
- Hears voices or sees things others do not see (hallucinations)
- Thoughts of hurting others
- Thoughts of hurting self, would be better dead
- Other concerns: _____

Is child able to attribute these feelings to a specific reason(s)? • No • Yes, specify: _____

Laboratory Testing*

Condition	Indicators	Test	Result
CBC w/ diff	<6 yrs <u>at IME</u>	• Blood/Serum	• Ordered • Pending; collected: ____/____/____
Lead	<6 yrs, lactating or pregnancy <u>at IME</u>	• Capillary, Lead	• Negative • Positive (≥3.5 µg/dL), level: ____
		• Blood/Serum, Lead	• Ordered • Pending; collected: ____/____/____
Pregnancy	≥10 yrs or <10 yrs who have reached menarche <u>at IME</u> , sexual activity/abuse/assault	• Urine pregnancy	• Negative • Positive • Indeterminate
HIV	All children <u>at IME</u>	• Rapid, fingerstick/oral	• Negative • Positive • Indeterminate
		• Blood/Serum, 4 th Gen	• Ordered • Pending; collected: ____/____/____
Syphilis	<2 yrs & not with biological mother <u>at IME</u> , sexual activity/abuse/assault	• RPR/VDRL	• Ordered • Pending; collected: ____/____/____
Chlamydia	Sexual activity/abuse/assault	• NAAT/PCR	• Ordered • Pending; collected: ____/____/____
Gonorrhea	Sexual activity/abuse/assault	• NAAT/PCR	• Ordered • Pending; collected: ____/____/____
Hepatitis B	Pregnancy, sexual abuse/assault, IDU, country-based	• Surface antigen	• Ordered • Pending; collected: ____/____/____
Hepatitis C	Pregnancy, IDU	• Total antibody	• Ordered • Pending; collected: ____/____/____
COVID-19	<u>Any</u> COVID-19 symptom, incl. but not ltd. to runny nose, sore throat, cough, headache, diarrhea	Rapid: • Ag • PCR	• Negative • Positive • Indeterminate
		• NAAT/PCR	• Ordered • Pending; collected: ____/____/____
Influenza	Fever + cough or sore throat	• Rapid flu	• Negative • Positive, type(s): • A • B • Unk
Strep throat	Sore throat + fever without cough, HCP discretion	• Rapid strep	• Negative, • culture ordered • Positive
Other Reportable Infectious	Specify: _____		• Ordered • Pending; collected: ____/____/____

Disease (Non-TB):	Specify:	☐ Ordered ☐ Pending; collected: ____/____/____
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TB Screening*					
Has child ever been exposed to a person with active TB disease? ☐ No ☐ Yes, specify: _____					
Has child ever been treated for TB? ☐ No ☐ Yes, specify type & details: ☐ Active TB disease ☐ Latent TB infection (LTBI)					
TB screening indicator	Test		Result		
<2 yrs of age at IME	• PPD/Tuberculin skin test (TST)	☐ Ordered	☐ Pending; date performed: ____/____/____, date read: ____/____/____; Result (mm): ____		
≥2 yrs of age at IME	TB blood test (IGRA): • QuantiFERON® -TB Gold In-Tube test (QFT-GIT) ☐ T-SPOT® .TB test (T-Spot)	☐ Ordered	☐ Pending; collected: ____/____/____		
≥15 yrs of age at IME	☐ Single view (PA) CXR	☐ Ordered	☐ Pending; performed: ____/____/____		
<15 yrs and + TST/IGRA or exposure/treatment history	☐ 2-view (PA and lateral) CXR	☐ Ordered	☐ Pending; performed: ____/____/____		
TB Screening Outcome:	☐ Pending ☐ Negative for TB condition; No further follow up needed	☐ TB, Latent (LTBI)	☐ Referred to Health Department/ specialist for active TB evaluation	☐ Not performed: _____	
If referred to HD/specialist, was an active TB work-up initiated?					
☐ No, specify reason: _____ ☐ Yes, specify reason: ☐ Signs/Symptoms ☐ Abnormal imaging ☐ Exposure history ☐ Initiation of LTBI treatment ☐ Other: _____ ☐ Specimen collected by HD/specialist: Specimen type: _____ Tests ordered: _____					
Diagnosis and Plan*					
Diagnosis: Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: ☐ No ☐ Yes If Yes , check all diagnoses that apply. Specify in the space provided, where indicated.					
General/Constitutional	HEENT	Respiratory/Pulmonary	Cardiovascular	Gastrointestinal	
- Allergic reaction - Allergy: _____ - Anemia - Dehydration - Developmental delay - Lead in blood - Fatigue - Lymphadenopathy - Obesity - Sickle cell disease - Underweight/Weight loss - Other: _____	- Allergic rhinitis - Cerumen impaction - Conjunctivitis - Hearing issues: _____ — - Otitis externa - Otitis media - Pharyngitis, strep - Pharyngitis, other - Vision issues: _____ — - Other: _____	- Abnormal CXR (Non-TB): _____ - Asthma, severity: _____ - Bronchiolitis - Chronic cough - Croup - Influenza, lab-confirmed - Influenza-like illness (ILI) - Pneumonia - Shortness of breath/wheezing - Upper respiratory illness - Other: _____	- Arrhythmia - Chest pain - Congenital heart disease: _____ - High blood pressure - Heart murmur - Myocarditis/Pericarditis/Endocarditis - Syncope/Fainting - Other: _____	- Abdominal pain - Appendicitis - Constipation - Diarrhea, acute/chronic - Failure to thrive - Gastritis/Peptic ulcer - Gastroenteritis - GI bleeding - Heartburn/Reflux - Inflammatory bowel disease - Intestinal parasites: _____ - Jaundice - Liver disease - Nausea/Vomiting - Other: _____	
Dental		Endocrine Disorder			
- Broken tooth/teeth - Gingivitis/Gum disease - Impacted tooth/teeth - Infection/abscess		- Missing tooth/teeth - Tooth decay/caries - Tooth sensitivity - Other: _____			
- Acanthosis nigricans - Delayed/Precocious puberty - Diabetes, Type 1 and 2		- Hyper/Hypothyroidism - Short stature - Other: _____			
Genito-urinary/Reproductive		Musculoskeletal	Potentially Reportable Infectious Disease		
- Abnormal vaginal discharge - Abortion - Amenorrhea/Abnormal uterine bleeding - Bed-wetting - Childbirth - Consensual sexual activity - Genital lesions - Gynecomastia/Breast mass - Herpes simplex virus - Inguinal hernia		- Kidney disease/stones - Menstrual cramping/pain - Miscarriage - Pelvic inflammatory disease - Pregnant, gestational age: ____ wks; est. due date: ____/____/____ - Proteinuria/Hematuria - Sexual abuse/assault - Testicular pain/Torsion - Urinary tract infection - Other: _____	- Back pain - Bone tumors (benign/malignant) - Extremity/Joint pain - Fracture - Hematoma/Bruise - Ligamentous/Tendon injury - Myalgia - Scoliosis/Kyphosis - Sprain/Strain - Other: _____	- Acute hepatitis A - Acute/chronic hepatitis B - Acute/chronic hepatitis C - Chikungunya - Chlamydia - COVID-19 - Dengue - Gonorrhea - HIV - Malaria - Measles - Mumps	- Pertussis - Rubella - Sepsis/Meningitis - Syphilis - TB, active disease - TB, latent (LTBI) - Typhoid fever - Varicella - Zika virus - Viral hemorrhagic fever: _____ - Other: _____
Neurological		Skin, Hair, and Nails			

- | | | | | |
|---|---|---|---|--|
| <ul style="list-style-type: none">• Brain tumor• Cerebral palsy• Cerebrovascular disease• Headache/Migraine• Seizure/Epilepsy | <ul style="list-style-type: none">• Traumatic brain injury/Concussion• Vertigo/Dizziness• Weakness• Other: _____ | <ul style="list-style-type: none">• Acne• Atopic dermatitis/Eczema• Cellulitis/Abscess• Contact dermatitis• Diaper rash• Hair loss/Alopecia areata | <ul style="list-style-type: none">• Impetigo• Ingrown toenail• Lice• Onychomycosis• Scabies• Scars | <ul style="list-style-type: none">• Tattoos• Tinea pedis/corporis/cruris/capitis• Urticaria• Warts• Other: _____ |
|---|---|---|---|--|

Medical, Other

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Behavioral and Mental Health Concerns

- Anxiety symptoms (e.g., panic attacks, excessive worry/fear)
- Depressive symptoms
- Manic symptoms (e.g., elated mood, pressured speech)
- Trauma symptoms (e.g., nightmares, flashbacks)
- Hallucinations
- Delusions
- Behavioral concerns (e.g., aggression, trouble following rules)
- Social/Emotional delay
- Urge for/current self-harm
- Urge for/current harm to others
- History of psychiatric diagnoses or treatment: _____
- Other: _____

Plan: Check all that apply and specify where indicated. Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

€ Immunizations administered during visit

€ Immunizations documented on foreign record reviewed and validated

€ Immunizations indicated but not given; specify: _____

€ Age-appropriate anticipatory guidance discussed and/or handout given

€ Child educated on healthcare services received and treatment recommendations

€ Medications administered/prescribed:

Medication Name	Reason	Date Started	Expected end date	Dose	Directions	Psychotropic?

€ Child requires isolation for a communicable disease; specify diagnosis, start/end dates: _____

• Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:

€ Onsite care provider clinician evaluation: _____

€ Increased level of supervision for mental health concern: _____

€ Assistance with daily living activities: _____

€ Durable medical equipment: _____

€ Physical activity restrictions: _____

€ Dietary restrictions: _____

€ Other: _____

€ Child has/may have an ADA disability: _____

• Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:

• Return to clinic: _____

• Mental health specialist evaluation: _____

• Medical specialist evaluation: _____

• Physical/Occupational/Speech therapy: _____

• Surgery/Procedure needed/performed: _____

• Other, specify: _____

Child cleared to travel:

• Yes, with no restrictions

• Yes, with restrictions (e.g., ground travel, travel safety plan, travel length): _____

• No, reason: _____

Recommendations from Healthcare Provider / Additional Information

Healthcare Provider Signature: _____

Date: ____/____/____

Healthcare Provider Printed Name: _____

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