

Medical Assessment Form (MAF)
Unaccompanied Alien Children Bureau
Office of Refugee Resettlement (ORR)

Instructions: The MAF must be completed by the evaluating healthcare provider (MD, DO, NP, PA, or PhD) as follows - Initial Medical Exam (IME), all 4 pages are required; routine well-child visits, pages 1-3 are required; all other scheduled assessments (e.g., PCP sick/follow-up visits, establish care visits, specialist visits), pages 1 & 2 are required, and page 3 is *recommended*. All healthcare providers must complete the 'Acknowledgement' section on page 3. Please refer to the MAF 'Dear Colleague' letter for additional guidance.

Child & Visit Information

Last name:	First name:	DOB:	Sex:
Setting: • In-person; • medical chaperone present for all/part of the physical exam • Telehealth		Date evaluated:	Time evaluated: AM / PM
Visit type: • IME • Routine well-child • Other preventive care (e.g., establish care, follow-up immunizations, counseling), • New complaint • Referral/Follow-up specify: _____			
Was an interpreter or translation service used in the performance of this assessment? • No • Yes, specify mode of service used during assessment: _____			
Chief complaint/History of present illness as reported by child and/or care provider staff:			

Visit Summary

Temperature	Heart Rate	Resp Rate	o2 Sat	BP (≥ 3 yrs)	Height	Weight
°C					cm	kg
Allergies: • No • Yes, specify, including reaction: _____ • Food: _____ • Medication: _____ • Environmental: _____						
Significant medical/mental health symptoms and exam findings (skip if page 3 will be completed):						

Assessment & Plan (Required for all visits)

Diagnoses: Note, please enter mental health concerns (e.g., anxiety symptoms, self-harm, trauma symptoms) instead of diagnoses when additional work-up is needed by a mental health professional (no ICD code needed)

ICD Code	Diagnosis/Mental Health Concern	Referrals & Follow-up appts. (e.g., Return to Clinic, PCP, OB/GYN, ER, Psychiatry, Dentist, PT, Mental health therapy)	Timeframe/Date, if applicable

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Plan: All fields required; please specify as indicated.

- No • Yes **Immunizations administered** during visit (please provide immunization record by end of visit)
- No • Yes **Immunizations indicated, but not given** and reason why: _____
- No • Yes **Procedures performed:** _____
- No • Yes **Lab testing/imaging** ordered/performed (including point-of-care tests, e.g., Flu, Strep) & status (Ordered, Collected) or result:
(Note, document all IME lab testing/imaging on page 4):

Test/Imaging Name	Status/Result	Test/Imaging Name	Status/Result	Test/Imaging Name	Status/Result
1.		3.		5.	
2.		4.		6.	

€ No • Yes **Medications** prescribed or administered during visit, including psychiatric, OTCs, and contraceptives:

Medication Name & Dose	Admin Route	Frequency	Indication, Check if Purpose is Psychiatric	Start Date	Duration	Refills
			• Psychiatric			
			• Psychiatric			
			• Psychiatric			
			• Psychiatric			
			• Psychiatric			

€ No € Yes **Verbal consent** from the authorized consentor and **assent** from the child were obtained for all prescribed psychotropic medications, specify name of authorized consentor: _____

€ No € Yes **Isolation** required for communicable disease: _____

€ No € Yes **Increased level of supervision** required for mental health risk: _____

€ No € Yes **Accommodation** required for a continuous or intermittent physical or mental impairment that is affecting/may affect a **major life activity/bodily function**:

Diagnosis causing impairment	Accommodation (e.g., bathing assistance, wheelchair, Epi-Pen, quiet areas, no-salt diet)	Duration (total expected)

- | | | |
|-----------------------------|------------------------------|--|
| ☐ No | ☐ Yes | Requires ongoing treatment/procedures (e.g., chemotherapy, dialysis) at a medical care facility |
| ☐ No | ☐ Yes | Travel restrictions (e.g., medical escort needed, ground travel only, pending results, no travel due to signs/symptoms, isolation, etc.): |
| | | |

Additional Information:

**** REMINDER: Please complete Acknowledgement section at the bottom of page 3 ****

Medical & Social History
Breastfeeding ☐ No ☐ Yes ☐ N/A

Past medical history including hospitalizations and surgeries:

History of sexual activity: ☐ No ☐ Yes, estimated date of last encounter ____ / ____ / ____ ☐ No response

History/Evidence of abuse: ☐ Denied ☐ Denied, but HCP concern ☐ Yes, specify below: ☐ No response

 ☐ Verbal/Emotional ☐ Physical ☐ Sexual abuse, est. date of last encounter: ____ / ____ / ____ ☐ Other: _____

Substance use: ☐ Denied ☐ Denied, but HCP concern ☐ Yes, specify below: ☐ No response

Substance	Freq of use	DLU	Substance	Freq of use	DLU	Substance	Freq of use	DLU
Alcohol			Ecstasy			Nicotine (e.g., cigarettes, vaping)		
Marijuana			PCP			Inhalants		
Other depressants			Other stimulants			Hallucinogens or Psychedelics		
Cocaine			Heroin			(e.g., LSD, mushrooms, mescaline)		
Crack			Other opiates					

Review of Systems
Did the child report any physical symptoms? ☐ No ☐ Yes, enter onset date (mm/dd/yy) or write 'unknown' if a date cannot be determined:

Pain, location: _____	Nausea/Vomiting	Neurologic symptoms
Fever (>37.8 C°) or chills	Urinary irregularities	Skin lesions/Rash
Red eyes	Diarrhea	Jaundice
Runny nose/Congestion	Neck stiffness	Swollen lymph nodes
Sore throat	Headache	Unusual bleeding
Cough	Dizziness	Other: _____
Difficulty breathing/SoB	Confusion/Altered mental status	Other: _____

Did the child report any mental health symptoms? ☐ No ☐ Yes, specify below:

- | | | |
|---|---|---|
| ☐ Feels empty, hopeless, sad, numb more often than not | ☐ Has paranoia or delusions | ☐ Relives traumatic events from the past |
| ☐ Feels constantly worried, anxious, nervous more often than not | ☐ Has trouble eating, sleeping | ☐ Feels afraid, easily startled, jumpy |

- Has trouble concentrating, restless, too many thoughts
- Experiences mood swings, from very high to very low
- Hears voices or sees things others do not see (hallucinations)
- Other: _____
- Has nightmares
- Engages in self-harm
- Feels easily annoyed or irritated
- Thoughts of hurting self, feels that they would be better dead
- Thoughts of hurting others

Physical Examination

Vision ($\geq$ 3 yrs): • Pass • Fail • Not performed at IME/well-child visit, specify reason: _____
Hearing: • Pass • Fail • Not performed at IME/well-child visit, specify reason: _____

System	Normal Findings	Notable Findings
General	• Well-appearing/nourished; no distress; euthymic affect; no delays noted	•
Head/Neck	• Normocephalic, neck supple; no adenopathy or masses	•
Eyes	• PERRL, EOMI; no redness/discharge	•
ENT/Dental	• TMs WNL; no rhinorrhea; clear oropharynx, normal dentition	•
Cardiovascular	• Regular rate & rhythm; no murmurs; normal pulses; cap refill < 3 sec	•
Lungs/Chest	• CTAB; no accessory muscle use; Tanner ____; no masses	•
Abdomen	• Non-distended; soft, non-tender; no masses/organomegaly	•
Genitourinary • Deferred	• External GU normal; Tanner ____; no lesions, discharge, hernia	•
Musculoskeletal	• FROM of all extremities; no joint swelling, erythema; no scoliosis	•
Neurologic	• Typical gait, strength, tone, sensation, speech & behavior for age	•
Skin	• No lesions, jaundice, pallor, scars, birthmarks, etc.	•

Acknowledgment (Required for all visits; for IME, continue to page 4)

I hereby confirm that the information that I have documented on this form is complete and accurate to the best of my ability. Furthermore, I agree to release all of the child's relevant health records to ORR, including but not limited to office notes, imaging results, and treatment plans to ensure continuity of care.

Healthcare Provider Signature: _____ Date: ____/____/____

Healthcare Provider Printed Name: _____ Credentials: _____ Speciality: _____

Clinic Name: _____ Phone #: _____

**** All sections on this page are required for the IME only ******Medical & Social History**

Travel history, including dates & countries:

Healthcare received in DHS custody/during journey:

Immunization history, reviewed & validated by HCP (must have documentation):

Tuberculosis history (active & latent):

- Active TB exposure (specify, including date of last exposure):
- Treatment (specify, including start & end dates):

Medications prescribed/taken within past 6 months (including psychiatric, vitamins, OTCs, and any contraceptives): • No • Yes, specify below:

Medication Name & Dose	Frequency	Indication	Date Started	Date Ended

Lab Testing & Imaging

Age/Risk Factor at IME	Required Test/Imaging	Status/Result
• All children	HIV: • 4 th Gen, venous OR • Determine HIV-1/2 Ag/Ab combo, rapid (only if $\geq$ 12 years of age) TB: • IGRA OR	• Ordered • Collected/Pending • Negative • Positive • Indeterminate • Ordered • Collected/Pending

	• TST (acceptable if 0-1 years of age only)	• Ordered	• Placed: ____/____, Read: ____/____ & Result: ____ mm
• 0-1 years <u>if biological mother is not in ORR care</u>	Syphilis, nontreponemal	• Ordered	• Collected/Pending
• 0-5 years of age	CBC with manual differential	• Ordered	• Collected/Pending
	Lead ¹ : • Rapid, capillary OR • Venous	• Negative	• Positive (≥ 3.5 $\mu\text{g/dL}$), level: _____
• Females ≥ 9 years • Females 0-8 years & risk for pregnancy	Pregnancy, urine	• Ordered	• Collected/Pending
• 0-14 years with + IGRA/TST • <u>Any</u> age with history of TB exposure/treatment	2-view (PA and lateral) CXR	• Negative	• Positive
• ≥ 15 years of age	Single view (PA) CXR	• Ordered	• Performed/Pending
• Sexual activity or abuse	Gonorrhea (NAAT, urine)	• Ordered	• Performed/Pending
	Chlamydia (NAAT, urine)	• Ordered	• Collected/Pending
	Syphilis (Nontreponemal)	• Ordered	• Collected/Pending
• Sexual abuse	Hepatitis B (sAg)	• Ordered	• Collected/Pending
• Pregnancy	Lead: • Rapid, capillary OR • Venous	• Negative	• Positive (≥ 3.5 $\mu\text{g/dL}$), level: _____
• Breastfeeding		• Ordered	• Collected/Pending
• Pregnancy	Pregnancy ultrasound	• Ordered	• Performed/Pending; est gest age (wks) _____
• Pregnancy, or	Hepatitis B (sAg)	• Ordered	• Collected/Pending
• Injectable drug use	Hepatitis C (Total Ab)	• Ordered	• Collected/Pending
• Born in country with $\geq 2\%$ HBV prevalence ²	Hepatitis B (sAg)	• Ordered	• Collected/Pending
Other lab testing/imaging ordered/performed (including point-of-care tests, e.g., Flu, Strep) & status (Ordered, Collected) or result:			
Test/Imaging Name	Status/Result	Test/Imaging Name	Status/Result
1.		3.	
2.		4.	
		5.	
		6.	

¹ Siblings of children with known elevated lead levels must also be screened for lead.² As of October 2026, areas with $\geq 2\%$ prevalence include much of Asia, the Pacific Islands, and most countries in Africa, particularly sub-Saharan Africa, as well as select countries in Europe, Latin America, and the Caribbean.