DEPARTMENT OF HEALTH

MINNESOTA INITIAL REFUGEE HEALTH ASSESSMENT FORM

Return completed form, preferably within 30 days of screening completion, to address on bottom of page 3.

Name (last, first, middle):	**Arrival Status:**
Date of Birth (month, day, year):	**Gender:**
Alien or Visa Registration#:	**Resettlement Agency:**
U.S. Arrival Date (month, day, year):	**Country of Origin:**
TB Class A or B Status:	

Date of First Clinic Visit for Screening (month, day, year): ___/___/_____

Date of Final Clinic Visit for Screening (month, day, year): ___ /____/____

Screening Clinic Information

Screening Clinic: _____

Physician/PA/NP Last:	**First:**

Address: **City:** **Zip Code:**

Name/title of person completing form _____**Phone**_____

Interpreter needed: ☐Yes, language(s) needed: _____ **☐ No**

Immunizations

Please attach immunization record of both overseas and/or domestic vaccinations to this form or specify MIIC ID below.

Minnesota Immunization Information Connection (MIIC) ID: _____

If immunizations were not given in U.S., list reason: _____

Lab evidence of immunity

Hepatitis A Total Antibodies:	☐ Positive	☐ Negative	☐ Indeterminate
Measles:	☐ Immune	☐ Not Immune	☐ Indeterminate
Mumps:	☐ Immune	☐ Not Immune	☐ Indeterminate
Rubella:	☐ Immune	☐ Not Immune	☐ Indeterminate
Varicella:	☐ Immune	☐ Not Immune	☐ Indeterminate

Tuberculosis Screening

Tuberculin Skin Test (TST) (regardless of BCG history)	**Chest X-Ray – done in U.S.** (If TST or IGRA positive, Class B, or symptomatic)	**Diagnosis** (must check one)	**Treatment** (for TB disease or LTBI)
Date TST placed (in U.S.): ____/____/_____	**Date of Chest X-Ray (in U.S.)**: _____/_____/____		**Start Date: __/__/____ OR Reason for not treating**
____mm Induration (not redness)	☐ Normal	☐ No TB infection or disease	
☐ Past history of positive TST (66)	☐ Abnormal, stable, old or healed TB	☐ Latent TB Infection (LTBI)*	☐ Declined treatment
☐ Given, not read (77)	☐ Abnormal, cavitary	☐ Old, healed not prev. Tx TB*	☐ Lost to follow-up
☐ Declined test (88)	☐ Abnormal, non-cavitary,	☐ Previously treated LTBI	☐ Moved out of MN
☐ Not done (99)	☐ Abnormal, not consistent with active TB	☐ Old, healed prev. Tx TB	☐ Pregnancy or Breastfeeding
☐ Given, not read (77)	☐ Abnormal, stable, old or healed TB	☐ Latent TB Infection (LTBI)*	☐ Declined treatment
☐ Declined test (88)	☐ Abnormal, cavitary	☐ Old, healed not prev. Tx TB*	☐ Lost to follow-up
☐ Not done (99)	☐ Abnormal, non-cavitary, consistent with active TB	☐ Previously treated LTBI	☐ Moved out of MN
	☐ Abnormal, not consistent with active TB	☐ Old, healed prev. Tx TB	☐ Pregnancy or Breastfeeding
Date of IGRA (in U.S.):___/___/___	☐ Pending	☐ Active TB disease – (suspected or confirmed)*	☐ Medical other than pregnancy
IGRA Test: ☐ QFT ☐ T-SPOT	☐ Declined CXR	☐ Pending	☐ Provider decision
☐ Positive	☐ Not Done	☐ Incomplete evaluation	☐ Further evaluation pending
☐ Negative			☐ Other:_____
☐ Indeterminate		**Complete TB treatment section*	
☐ Borderline			
☐ Not Done	***TB treatment follow-up clinic if not the same as screening clinic:***_____		

Alien Number: _____

Hepatitis B and D Screening

1. Anti-HBs (✓ one)	☐Negative ☐Positive; Note if positive, patient is immune. ☐Indeterminate ☐Results pending ☐Not done
2. HBsAg (✓ one)	☐Negative ☐Positive* ☐Indeterminate ☐Results pending ☐Not done
3. Anti-HBc (✓ one)	☐Negative ☐Positive ☐Indeterminate ☐Results pending ☐Not done

*If positive for HBsAg, **anti-HDV** (✓ one) ☐Negative ☐Positive ☐Indeterminate ☐Results pending ☐Not done

Hepatitis C Screening

Anti-HCV (✓ one)	☐Negative ☐Positive ☐Indeterminate ☐Pending ☐Not done **HCV CONFIRM** ☐Negative ☐Positive

Sexual and Reproductive Health *(check one for each of the following)*

1. Syphilis Non-Treponemal Test (RPR-VDRL)	☐Negative ☐Positive ☐Pending ☐Not done	Treated for Syphilis in U.S.? ☐Yes ☐No ☐Referred
Syphilis Treponemal Test (i.e EIA, TP-PA)	☐Negative ☐Positive ☐Pending ☐Not done	
2. Gonorrhea	☐Negative ☐Positive; treated: ____yes ____no ☐Pending ☐Not done	
3. Chlamydia	☐Negative ☐Positive; treated: ____yes ____no ☐Pending ☐Not done	
4. HIV	☐Negative ☐Positive; treated: _yes ____no ☐Pending ☐Not done	**HIV CONFIRM** ☐Negative ☐Positive

Female Genital Cutting/Circumcision *(answer the following questions for all female patients from countries where FGM/C is practiced)*

1. Has the patient has been cut/circumcised? ☐Yes ☐No ☐Deferred
   FGM/C status determined by ☐ Physical exam ☐ History collection

2. If patient has been cut/circumcised, and pelvic exam was done, indicate type of cut: ☐ type I ☐ type II ☐ type III

3. If pelvic exam was deferred, was patient referred to primary care? ☐Yes ☐No

CBC with differential done? ☐Yes ☐No

If yes, was Eosinophilia present? ☐Yes ☐No ☐Results pending | If yes, was further evaluation done? ☐Yes

Intestinal Parasite Screening

1. Was screening for parasites done? (✓ one) ☐Yes ☐No If No, why not? _____

2. Serology Test	☐Done ☐Results Pending ☐Not done	
Schistosoma	☐Negative ☐Positive; treated: ___yes ___no ☐Indeterminate ☐Results Pending ☐Not done	
Strongyloides	☐Negative ☐Positive; treated:___ yes ___no ☐Indeterminate ☐Results Pending ☐Not done	
3. Stool (O&P) Test	☐No parasites found	☐Results Pending
	☐Non-pathogenic parasites found ○Blastocystis; treated: ___yes___no	☐Not Done
	☐Pathogenic parasite(s) found	

(If positive for pathogenic parasite(s) by O&P, check all that apply)

☐ Schistosoma Treated? ☐Yes ☐No Species:_____ ☐ Giardia Treated? ☐Yes ☐No ☐Trichuris Treated? ☐Yes ☐No ☐Hookworm Treated? ☐Yes ☐No	☐Strongyloides Treated? ☐Yes ☐No ☐E. histolytica Treated? ☐Yes ☐No ☐Hymenolepis Treated? ☐Yes ☐No ☐Paragonimus Treated? ☐Yes ☐No	☐Ascaris Treated? ☐Yes ☐No ☐Dientameoba Treated? ☐Yes ☐No ☐Clonorchis Treated? ☐Yes ☐No ☐Other (specify) T reated? ☐Yes ☐No

If not treated, why not?

Malaria Screening

☐ Not screened for malaria ☐ Presumptively treated for malaria **in the U.S**.

☐ Screened, no malaria species found in blood smears

☐ Screened, malaria species found (please specify): _____

If malaria species found: Treated? ☐ Yes ☐ No → Referred for malaria treatment? ☐ Yes ☐ No

If referred for malaria treatment, specify physician/clinic: _____

☐ Screened, results pending

Alien Number: _____

Labs and Measurements (*fill in for all refugees*)

Height (in)	Weight (lbs)	Head Circum. (< 3 yrs old, cm)	Pulse	BP- Sys/Dias
Blood Glucose (mg/dL)	Hemoglobin	Hematocrit (%)	Vit. D Total (ng/ml)	Lead (<17 yrs old; Pregnant/BF)

Other Health Conditions

Pregnancy Test ☐Positive ☐Negative ☐Not done	**Hearing Problems** ☐Yes ☐No ☐Not done
Currently Breastfeeding ☐Yes ☐No	**Dental Problems** ☐Yes ☐No ☐Not done
Vision Loss ☐Yes ☐No ☐Not done	**Addtl. Health Concern? (list)** _____

Mental Health

Screened for Mental Health ☐Yes ☐No If No, why not? _____

A. If screened, mental health screening tool used: (check one)

☐ WE Check: Minnesota Well-being Check (for ages 18+) ☐ Other (please specify): _____

For the WE Check: Minnesota Well-being Check only, specify results below:

1. In the past month, have you felt too sad? ☐Yes ☐No ☐Not asked
2. In the past month, have you been worrying or thinking too much? ☐Yes ☐No ☐Not asked
3. In the past month, have thoughts about the past kept you from doing things or spending time with others? ☐Yes ☐No ☐Not asked
4. In the past month, did you have sleep problems? ☐Yes ☐No ☐Not asked
5. In the past month, did you have memory problems? ☐Yes ☐No ☐Not asked
6. *If any of the above answers were yes*: Did any of the above stop you from doing things you need to do every day? ☐Yes ☐No ☐Not asked

B. Mental Health Screening outcome (*all screening tools*): ☐Positive (mental health concerns identified) ☐Negative

If positive, was mental health referral made? ☐Yes, in primary care setting ☐Yes, in specialty care setting ☐No

Referrals (check all that apply)

☐ Primary Care / Family Practice	☐ Dentistry	☐ Ophthalmology/Optometry	☐ Audiology/Hearing
☐ Cardiology	☐ Hematology/Oncology	☐ Neurology	☐ Radiology
☐ Dermatology	☐ Immunology/Allergy	☐ Nutrition	☐ Surgery
☐ Ear, Nose & Throat (ENT)	☐ Infectious Disease	☐ Pediatrics	☐ Urology
☐ Emergency/Urgent Care	☐ Internal Medicine	☐ Public Health Nurse (PHN)	☐ WIC
☐ Endocrinology	☐ OB/GYN or Family Planning	☐ Social Services	☐ Gastroenterology (GI)
☐ Home Care/PCA	☐ Nephrology	☐ Orthopedics	☐ Occupational/Physical Therapy

☐ Other Referral:_____

Reimbursement/Insurance Information

☐ Straight MA	MHCP/MA ID # _____	**Activation Date:** ____/_____/_____
☐ PMAP (specify health plan):_____	MHCP/PMAP ID#: _____	**Activation Date:** ____/_____/_____
☐ Private third party payer	☐ Other (specify) _____	☐ No Insurance

☐ Flat Fee* (*A flat fee reimbursement is available to clinics that screen refugees without health insurance. Must be a primary refugee, screened within 90 days of arrival, and with complete exam. Call (651) 201-5414 for more information.

Note: Fill out the Minnesota Refugee Health Assessment Form indicating the results of the tests listed on this form and return to the local public health agency noted below within 30 days of completion of screening. For more information, contact the Refugee Health Program, Minnesota Department of Health at (651) 201-5414.

RETURN/MAIL TO: (Local Public Health Agency)
Address: _____

_____

_____

Phone: _____

Find the Minnesota current refugee screening guidance materials at www.health.state.mn.us/refugee

Use **CareRef**, the interactive clinical tool, to get a person-specific screening guidance https://careref.web.health.state.mn.us/

Revised 10/21

Minnesota Department of Health Initial Health Screening Tests Recommended for All Refugees

The comprehensive **Refugee Health Assessment** includes complete history, review of systems, physical examination, and laboratory testing. Infectious diseases and chronic conditions are both within the scope of the assessment. Evaluate for cardiovascular conditions, diabetes, hematologic disorders (eosinophilia, anemia, and microcytosis), nutritional deficiencies, thyroid disease, otorhinologic and dermatologic abnormalities. Record vital signs and anthropometric measurements. Perform urinalysis for any patient old enough to produce a clean catch specimen, and conduct dental, vision, and hearing evaluations. Refer to the Minnesota Domestic Refugee Health Screening Guidance (www.health.state.mn.us/communities/rih/hcp/index.html) or CareRef (https://careref.web.health.state.mn.us/).

Disease or Condition	Screening Recommendations
Immunizations	All refugees should be offered vaccinations for which they are currently eligible under ACIP guidelines (catch-up guidelines may be appropriate). Review overseas vaccinations received on DS-3025 overseas exam and ask patient if they have personal copies of vaccinations received overseas. Documented vaccine doses administered outside the United States should be accepted as valid if schedules and doses are compatible with ACIP recommendations. Checking for laboratory evidence of immunity (i.e., titer) is an acceptable alternative to vaccination; however, the clinician should be familiar with the appropriateness and interpretation of available serologic tests when relying on testing as proof of immunity. If you need assistance translating immunization records or determining needed immunizations, call CDC hotline 800-CDC-INFO (1-800-232-4636).
Tuberculosis (TB)	Perform a blood interferon gamma assay (IGRA) or tuberculin skin test (TST) for TB for all individuals regardless of BCG history, unless documented previous positive IGRA test. Either IGRA or TST are acceptable tests; however, IGRA is preferred for persons ≥2 years of age. Pregnancy is not a medical contraindication for IGRA or TST testing or for treatment of active or latent TB. TST administered prior to 6 months of age may yield false negative results. • A chest x-ray should be performed for all individuals with a positive IGRA or TST test • A chest x-ray should be performed for all individuals with a positive IGRA test from their overseas medical exam (Class B2) • A chest x-ray should also be performed **regardless of IGRA or TST results** for: o those with a TB Class A or B1 designation from overseas exam or o those who have symptoms compatible with TB disease.
Hepatitis B and D	Administer a hepatitis B screening panel including hepatitis B surface antigen (HBsAg), hepatitis B surface antibody (anti-HBs), and hepatitis B core antibody (anti-HBc) to all refugees, regardless of age, vaccine history, or overseas testing results. Test for Hepatitis D in those with a positive HBsAg. Refer all persons with chronic HBV infection for additional ongoing medical evaluation.
Hepatitis C	Universal hepatitis C screening should be implemented for all new adult arrivals (≥18 years of age). Testing should consist of anti-HCV and, if positive, HCV RNA testing. Test for HCV in children <18 years with risk factors (HCV-positive mother, injection drug use, HIV infection, unaccompanied refugee minor, chronic hemodialysis, signs or symptoms of liver disease, household contacts with HCV, history of female genital mutilation or cutting). Because anti-HCV testing in children younger than 18 months may be falsely positive due to detection of passively acquired maternal antibody, testing prior to age 18 months should consist of HCV RNA testing. Refer all persons with chronic HBV infection for additional ongoing medical evaluation.
Intestinal Parasites	• **All Refugees** Evaluate for eosinophilia by obtaining a CBC with differential (eosinophilia >400 cells/mcl) If positive for eosinophilia, re-check for eosinophilia 3-6 months after arrival • **Refugees from Asia, Middle East, North Africa, Latin America, or Caribbean** *If no pre-departure albendazole*: Provide presumptive albendazole treatment, or conduct stool ova and parasites *If no pre-departure ivermectin*: Provide presumptive ivermectin therapy or conduct serology for

	Strongyloides • **Refugees from sub-Saharan Africa** *If no pre-departure albendazole*: Provide presumptive albendazole treatment, or conduct stool ova and parasites *If no pre-departure ivermectin*: Provide presumptive ivermectin therapy or conduct serology for Strongyloides**. Do not** provide presumptive ivermectin therapy to refugees from *loa loa*-endemic regions of sub-Saharan Africa unless *loa loa* infection can be ruled out. *If no pre-departure praziquantel*: Provide presumptive praziquanteltherapy or conduct serology for Schistosomiasis
HIV	Routine screening for HIV, ages 13- 64 years. Screening those <13 and ≥65 is also encouraged. Children <13 should be screened unless mother has negative HIV status and child is otherwise at low risk. In most situations, complete risk factor info is unavailable, and child should be screened. If positive for HIV antibodies, ensure specific HIV-2 testing for those native to or transmitted through West Africa. Children <18 months who test positive for HIV antibodies should receive further testing with DNA or RNA assays, as antibody tests can be unreliable at this age, as they may detect persistent maternal antibody.
Sexual and Reproductive Health	Test all those ≥15 years for syphilis infection, unless treated for syphilis pre-departure. For patients with documented history of syphilis diagnosis and treatment, perform serologic re-evaluation at 6 and 12 months post-treatment (2-3 months for pediatric patients). Test refugees <15 years if risk factors are present. Test all refugees <25 years for chlamydia and gonorrhea if sexually active and no documentation of overseas testing. Test refugee ≥25 years if risk factors are present (e.g., new sex partner or multiple sex partners, sex partner with concurrent partners, history of sexual abuse, or sex partner who has a sexually transmitted infection), and no documentation of overseas testing. Screen women and girls from countries where female genital mutilation/cutting (FGM/C) is practiced (UNICEF Data: Female Genital Mutilation (FGM) [https://data.unicef.org/topic/child-protection/female-genital-mutilation/]) for possible FGM/C-associated medical complications, including chronic pain and recurrent urinary tract infections.
Malaria	Screen any refugee who presents with symptoms suspicious of malaria. For asymptomatic refugees from sub-Saharan Africa, screen or presumptively treat (preferred) if no documented pre- departure therapy and within 3 months of U.S. arrival (note contraindications for pregnant women and children < 5 kg).
Lead	Venous blood lead level (BLL) screening is recommended for all refugee children under 17 years, and refugees who are pregnant or breastfeeding. For those with elevated BLL ≥3.5 µg/dL, check for lead sources and check BLLs in all family members. Ensure follow up management. Within 3-6 months after initial testing, a blood lead test should be repeated for all refugee infants and children ≤6 years of age, regardless of initial screening result. Prescribe daily pediatric multivitamins with iron for refugee children 6 to 59 months of age.
Mental Health	Screen all adults ≥18 years for mental health distress using the **WE-Check: Minnesota Well-being and Emotions Check**. Assess children <18 years for mental health distress using a structured or semi-structured assessment, integrated into the overall health assessment. For those in need of mental health support and assistance, develop an action plan with associated management and/or referral.

NOTICE FOR HEALTHCARE PROVIDERS REGARDING RELEASE OF INFORMATION

Information on this Refugee Health Assessment Form is collected for the Minnesota Department of Health (MDH), by authority of 8 U.S. Code Chapter 12, Subchapter IV, Section 412(c)(3)* of the Immigration and Nationality Act. The information you or your clinic provide is used to obtain a health evaluation and/or treatment for the patient. It can also facilitate the individual's enrollment into a school, childcare, or early childhood programs as required by Minnesota Statutes §121A.15. MDH may release this information on the form to health care providers or agencies which are involved in the care of the individual. These health care providers and agencies usually include medical, mental and dental care providers, public health agencies, hospitals, schools, childcare centers and early childhood programs. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services will be entitled to the information included on this form.

Although some of the information collected includes legally reportable diseases (MN Rules Chapter 4605), there is no obligation to provide supplemental information and the client will receive health care services even if your entity does not provide the supplemental information. However, if the information is not provided, it may result in delay of services or denial of enrollment into a Minnesota school, childcare center or early childhood program because information may not be shared with agencies.

MDH protects private data in accordance with the Government Data Practices statutes, Minnesota Statutes, Chapter 13.

Why is MDH asking for the information?

- To help the patient get medical, dental, or mental health services to ensure they receive appropriate health care;
- For school, childcare, or early childhood enrollment to aid in enrollment in these programs;
- To make reports, do research, conduct audits, evaluate refugee programs and develop interventions and educational/outreach activities to ensure refugees received appropriate health care.

With whom may this information be shared?

- Healthcare providers, including medical, mental and dental healthcare providers, public health agencies, and hospitals involved in the care of the refugee
- Schools, childcare centers or early childhood programs, for enrollment
- Local, state, or federal public health agencies conducting program evaluations to ensure refugees receive appropriate care.

For more information, contact: The Refugee Health Program, Minnesota Department of Health
625 Robert Street N | P. O. Box 64975 | St Paul, MN 55164-0975
(651) 201-5414 (metro) | 1-877-676-5414 (toll-free)| refugeehealth@state.mn.us
www.health.state.mn.us/refugee

DEPARTMENT OF HEALTH