

Initial Medical Exam Unaccompanied Children's Program Office of Refugee Resettlement (ORR)

General Information (to be completed by program staff)

Child	Last name:		First name:		
	DOB:		A#:		Gender:
Healthcare Provider	Name: MD / DO / PA / NP		Phone number:		Clinic or Practice:
	Street address:		City or Town:		State: Date of visit:
Program	Name of program staff with child:			Program name:	

History and Physical (to be completed by healthcare provider)

Vital Signs

T (C°):	HR:	BP (≥ 3 years):	RR:	Ht (cm):	Wt (kg):
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Allergies € Check if none

€ Food, specify:	€ Medication, specify:	€ Other, specify:
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Vision (≥ 5 years)

	Right Eye	Left Eye	Both eyes
Corrected	20 /	20 /	20 /
Uncorrected	20 /	20 /	20 /

Medical History

Concerns expressed by child or caregiver:	€ No concerns
Past medical history (include surgeries and hospital admissions):	
Family History:	
Reproductive History:	LMP: ___ / ___ / ___ or € N/A Previous pregnancy: G ___ P ___ or € N/A

Review of Systems (ROS)

Check all applicable signs and symptoms and enter the date each began:

€ No abnormal findings	€ Pain, location: _____ /___/___
€ Fever (>37.8 C°) or chills ___/___/___	€ Red eyes ___/___/___
€ Runny nose ___/___/___	€ Sore throat ___/___/___
€ Cough ___/___/___	€ Difficulty breathing / Shortness of breath / Wheezing ___/___/___
€ Nausea ___/___/___	€ Vomiting ___/___/___
€ Diarrhea ___/___/___	€ Neck stiffness ___/___/___
€ Headache ___/___/___	€ Confusion/Altered mental status ___/___/___
€ Dizziness ___/___/___	€ Neurologic symptoms ___/___/___
€ Skin lesions or rash ___/___/___	€ Yellow skin or eyes ___/___/___
€ Swollen glands ___/___/___	€ Unusual bleeding ___/___/___
€ Other 1, specify: _____	_____ /___/___
€ Other 2, specify: _____	_____ /___/___

Physical Examination

Check each system to indicate if normal or abnormal and describe. Leave blank if not evaluated:

System	Normal	Abnormal	Describe
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
GU/GYN	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Back/Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	
Skin (include tattoos)	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	

Psychosocial Risk

In each section, place a check next to each reported condition/history/behavior & describe where applicable:

Mental Health (Over the past 3 months) Check if no concerns

- 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
- Feels helpless
- Feels like hurting others
- Feels like hurting self, would be better off dead
- Other concerns: _____

Physical Abuse History Check if physical abuse is denied

- Victim of physical abuse, specify who/when/where: _____
- In home country
- In US, not in ORR custody
- During journey to U.S.
- In ORR custody

Sexual Activity/Abuse History Check if sexual activity or abuse are denied

- Consensual sexual activity (oral/vaginal/anal)
- Sexual abuse, specify who/when/where: _____
- Previous STD diagnosis, specify: _____
- In home country
- In US, not in ORR custody
- During journey to U.S.
- In ORR custody

Substance Use Check if substance use is denied

- IVDU:
- Alcohol:
- Tobacco:
- Other:

Laboratory Testing

Ordered	Test	Indicators	Result		
			Positive	Negative	Indeterminate
<input type="checkbox"/>	Flu, rapid	Fever + cough or sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	HIV	≥ 13 yrs or Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Pregnancy	≥ 10 yrs or Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Lead (positive ≥ 5 mcg/dl)	6 mos - 6 yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis B surface antigen	Sexual activity/IVDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis C antibody	IVDU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Syphilis RPR/VRDL	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Chlamydia NAAT	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Gonorrhea NAAT	Sexual activity/abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TB Screening (Use Supplemental TB Screening form for result documentation)

- Has child ever been a close contact to someone with **active** TB disease? No Yes, specify: _____
- Has child ever been treated for **active** TB disease? No Yes, specify: _____
- Has child ever been treated for **latent** TB infection? No Yes, specify: _____
- TB screening method ordered:** TST IGRA CXR Was or will be tested elsewhere

Assessment and Plan

Assessment: Child without complaints, symptoms, diagnoses/conditions; no meds (including OTC) or referrals needed: No Yes
 If No, check all diagnoses that apply. If "Other" is selected, specify in the space provided.

General/Constitutional

- Allergy (e.g., drug reaction, food allergy), specify: _____
- Dehydration Malnourished
- Other: _____

HEENT

- Headache/Migraine Hearing issues
- Otitis media/Ear infection Pharyngitis (Not strep throat)
- Rhinitis Strep throat
- Vision issues • Viral/Bacterial Conjunctivitis
- Other: _____

Respiratory/Pulmonary

- Asthma Influenza-like illness (ILI)
- Influenza, lab-confirmed; specify: _____
- Upper/lower respiratory illness; specify: _____
- Other: _____

Cardiovascular

- Heart murmur Syncope/fainting
- Other: _____

Gastrointestinal

- Abdominal pain Gastroenteritis
- Heartburn/reflux Intestinal parasites
- Other: _____

Genito-urinary/Reproductive

- Childbirth Pregnancy/Pregnancy-related
- Genital warts Urinary tract infection
- Other: _____

Neurological

- Developmental delay Seizure/epilepsy
- Other: _____

Musculoskeletal

- Back pain Fracture
- Leg pain Sprain/Strain
- Other: _____

Skin, Hair, and Nails

- Cellulitis Dermatitis/Rash (not acne)
- Ingrown toenail Lice
- Scabies Tinea pedis
- Other: _____

Potentially Reportable Infectious Disease

- Acute hepatitis A Acute/chronic hepatitis B
- Acute/chronic hepatitis C Chikungunya
- Chlamydia Dengue
- Gonorrhea HIV
- Malaria Measles
- Mumps Pertussis
- Rubella Sepsis/Meningitis
- Syphilis TB
- Typhoid fever Varicella
- Viral hemorrhagic fever, specify: _____
- Zika virus
- Other: _____

Abuse

- Sexual; where/when: _____
- Physical; where/when: _____
- Other: _____

Other, Medical:

Behavioral and Mental Health Concerns

- ADHD/ADD Adjustment disorder
- Anxiety disorder Bipolar disorder
- Borderline personality disorder Depressive disorder
- Panic disorder PTSD
- Schizophrenia Self-injury/cutting
- Suicide ideation/attempt
- Other: _____

Plan: Check all that apply and specify in the space provided.

Return to clinic:

- PRN/As needed Follow-up (specify condition, timing): _____

Referred to specialist/counselor: _____

Prolonged treatment/therapy (e.g., physical therapy): _____

New/Current medications (specify name, reason, date started, dose, and directions and indicate if psychotropic): _____

Immunizations given/validated from foreign record

List immunizations not given due to medical contraindication: _____

Age-appropriate anticipatory guidance discussed and/or handout given

Child quarantined/isolated at the program for a diagnosis, specify: _____

Release of child delayed from the program because of a diagnosis, specify: _____

Other: _____

Additional Information

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Potentially Reportable Infectious Diseases

Lab testing performed to confirm the diagnosis:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
Health department notified by program:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not applicable
Intakes delayed/postponed because of this diagnosis:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
UAC exposed to this child while infectious:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(Complete a Contact Investigation Form for each exposed UAC)
Number of staff members exposed to this diagnosis:			

Potentially Reportable Infectious Disease (Non-TB) Lab Testing

Disease Tested	Collection Date	Specimen Type (e.g., Serum)	Test Type (e.g., IgM)	Result

Please provide copies of office notes, lab/imaging results, and immunization records to program staff.

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