

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):
Allergies € Check if none					
€ Food, specify:		€ Medication, specify:		€ Other, specify:	
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:					
Travel history (countries visited, dates of arrival and departure for each):					
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

- | | |
|---|---|
| <input type="checkbox"/> Feels empty, hopeless, sad, numb more often than not | <input type="checkbox"/> Has trouble concentrating, restless, too many thoughts |
| <input type="checkbox"/> Feels constantly worried, anxious, nervous more often than not | <input type="checkbox"/> Has trouble eating, sleeping |
| <input type="checkbox"/> Experiences mood swings, from very high to very low | <input type="checkbox"/> Feels helpless |
| <input type="checkbox"/> Relives traumatic events from the past | <input type="checkbox"/> Feels like hurting others |
| <input type="checkbox"/> Feels easily annoyed or irritated | <input type="checkbox"/> Feels like hurting self, would be better off dead |
| <input type="checkbox"/> Feels afraid, easily startled, jumpy | <input type="checkbox"/> Other concerns: _____ |

Physical Abuse History Check if physical abuse is denied

- | | | |
|--|--|---|
| <input type="checkbox"/> Victim of physical abuse, specify who/when/where: _____ | <input type="checkbox"/> In home country | <input type="checkbox"/> During journey to U.S. |
| _____ | <input type="checkbox"/> In US, not in ORR | <input type="checkbox"/> In ORR custody |
| _____ | custody | |

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

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

Substance Use Check if substance use is denied

- | | | | |
|--------------------------------|-----------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> IVDU: | <input type="checkbox"/> Alcohol: | <input type="checkbox"/> Tobacco: | <input type="checkbox"/> 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 up to 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 COVID-19
- Dengue Gonorrhea
- HIV Malaria
- Measles Mumps
- Pertussis Rubella
- Sepsis/Meningitis Syphilis
- TB Typhoid fever
- Varicella Zika virus
- Viral hemorrhagic fever, specify: _____
- Other: _____

Abuse

- Sexual Physical
- 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

Potentially Reportable Infectious Diseases

Specify the reportable infectious disease diagnosed:

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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