Ohio Department of Job and Family Services

Refugee Health Screening

1. Effective July 1, 2009, this form is to be used **only** when Web-based reporting is unavailable.
2. Please see the Core Screening Procedures for detailed instructions. Note: Section I, "Demographics" MUST be typed.
3. Screening must begin within 90 days of arrival/status granted. If beyond 90 days contact ODJFS for possible exceptions.
4. Questions? Call the ODJFS Refugee State Coordinator's Office at (614) 644-1142 for more information.

Submit Summary Page and Invoice to:
Refugee Services, Office of Family Stability, ODJFS
P.O. Box 182709, Suite 400, 6th Floor
Columbus, OH 43218-2709

Or Via E-mail:
Sarah.Russell@jfs.ohio.gov

Section I	Refugee Personal and Demographic Information						
Last Name:		First & Middle:					
Address:							
City:		State: OH	Zip:		County:		
Phone:		Resettlement Agency:			Gender:	☐ Male	☐ Female
Alien #:		I-94 Status (Place Copy in Chart):					
Country of Origin:		Primary Language:					
Interpreter Needed:	☐ Yes ☐ No	Language Used:					
Interpreter Name:		Interpreter Agency:					

Section II	Dates		
Arrival / Status Granted Date:		Date of Birth:	
Health Screening Start Date:		Location/Site:	
Health Screening Assessment Date:		Location/Site:	

Section III	Screening Provider Information (Provider Use Only)		
Provider:		Phone:	
Contact Name:		Fax:	

Section IV	Overseas Medical Document Review	
List Class A or B Conditions identified during overseas health assessment. Include IOM Bag, DS-2053 (OF-157) and other overseas documents. Use one line for each condition.	Diagnosis Confirmed	Comments
	☐Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
Notes:		

Section V	Health Education: 30 Minutes Orientation to the U.S. Health Care System	
Completed Date:	Not done, explain:	

Name : (Last, First Middle)		Alien #:	

Section VI	**Physical Exam**				
Medical History Completed:	☐ Yes	☐ No	If not completed, please explain:		
↓CHILDREN ONLY (<16) ↓					
Head Circumference:	cm	Blood Lead Level:		Blood Lead Test Date:	
↓ALL AGES ↓					
Height:		Weight:		NOTES	
Temp:		Pulse:			
BP Sys:		BP: Dias:			
Visual Acuity:	Normal / Refer to Specialist	Oral Exam:	Normal / Refer to Specialist		
Hearing:	Normal / Refer to Specialist	Speech:	Normal / Refer to Specialist		
Complete Blood Count with Differential					
WBC:		MCV:			
Hemoglobin:		Hematocrit %:			
Eosinophils:		Serum Glucose:			
Urinalysis	Specific Gravity:		pH:		

Immunization Record: Review overseas records if available, and document immunization dates.
For measles, mumps, rubella, varicella: Indicate lab evidence of immunity **date**. If immune, do not immunize for that particular disease.
For all other immunizations: Update series or begin primary series if no immunization dates are found.

Section VII	**Immunization Status**					
	Number of Doses Given or Positive Serology	Last Date Given or Serologic Test Date Mo/Day/Year		Last Date Given or Serologic Test Date Mo/Day/Year		Last Date Given or Serologic Test Date Mo/Day/Year
Measles:			HPV:		Polio (IPV):	
Mumps:			Zoster:		Pneumococcal:	
Rubella:			Hepatitis B:		Meningococcal:	
Varicella (VZV):			Influenza:		Haemophilus influenzae type b (Hib):	
Diphtheria-Tetanus (Td, Tdap) Circle vaccine type:			Hepatitis A:		Diphtheria, Tetanus and Pertussis (DTaP, DTP, DT) Circle vaccine type:	
BCG History?	Yes -Provide date: / /	☐ No	☐ Unknown			

Section VIII	**Parasite Screening**											
STOOL	Screened, pathogenic parasites found. **↓ ↓ ↓ Please list below. ↓ ↓ ↓**					☐	Screened. **No** parasites found.	☐	Screened. **Non-pathogenic** parasites found.			
☐	Ascaris → Treated?	☐	Yes	☐	No	☐	Hookworm → Treated?	☐	Yes	☐	No	
☐	Clonorchis → Treated?	☐	Yes	☐	No	☐	Paragonimus → Treated?	☐	Yes	☐	No	
☐	Entamoeba histolytica→Treated?	☐	Yes	☐	No	☐	Schistosoma → Treated?	☐	Yes	☐	No	
☐	Strongyloides→Treated?	☐	Yes	☐	No	☐	Trichuris → Treated?	☐	Yes	☐	No	
☐	Giardia → Treated?	☐	Yes	☐	No	☐	Other: Specify → Treated?	☐	Yes	☐	No	
If not treated, please explain:												
BLOOD	**Malaria:**	☐	Screened-no malaria found			☐	Not screened- no symptoms, history or geography					
		☐	Screened, malaria species found, please specify _____ → Treated?			☐	Yes	☐	No			
Parasitic Screening Comments:												

Name : (Last, First Middle)		Alien #:	

Section IX	**Tuberculosis Screening**			Site of TB Screening :							
Date:	Tuberculin Skin Test (TST) (regardless of BCG history)		mm Induration (not redness)	☐	Past history of positive TST (66)	☐	Given, not read (77)	☐	Declined test (88)	☐	Not done (99)
Date:	Blood Assay Mycobacterium Test (e.g., QuantiFERON Gold)			☐	Negative	☐	Positive	☐	Indeterminate	☐	Not done (99)

Date:	**Chest X-Ray** -- done in US (If TST or BAMT positive, Class B or symptomatic)										
☐	Normal	☐	Abnormal	☐	Stable, old or healed TB	☐	Cavitary	☐	Non-cavitary, consistent with active TB	☐	Not consistent with active TB
☐	Pending	☐	Incomplete evaluation, or Lost to follow up								
Diagnosis (Must check one)	☐	No TB infection or disease	☐	**Latent TB Infection (LTBI)**	☐	Old, healed **NOT** prev. Tx TB	☐	Old, healed prev. Tx TB	☐	**Active TB disease (susp. or confirmed)**	
☐	Pending	☐	Incomplete evaluation or Lost to follow up								

Treatment: **For all TB disease or LTBI patient must be referred to local TB Control / Public Health**	Referred: ☐ Yes
TB Testing Comments:	

Section X	**Hepatitis B Screening**							
Anti-HBs (check one)	☐	Negative	☐	Positive	☐	Indeterminate	☐	Not done
Anti-HBc (check one)	☐	Negative	☐	Positive	☐	Indeterminate	☐	Not done
HBsAg (check one)	☐	Negative	☐	**Positive***	☐	Indeterminate	☐	Not done

* Note: if positive HBsAg, patient is infected with HBV and infectious to contacts. It is especially important to screen **ALL** household contacts.

If positive HBsAg, were all household contacts screened?	☐	Yes, **all**	☐	**Some**, not all contacts screened	☐	No, none

Section XI	**Sexual History and Sexually Transmitted Infections**					
Syphilis	☐	Negative	☐	+ treated	☐	+ not treated	Not done, explain:
Gonorrhea	☐	Negative	☐	+ treated	☐	+ not treated	Not done, explain:
Chlamydia	☐	Negative	☐	+ treated	☐	+ not treated	Not done, explain:
HIV	☐	Negative	☐	+ treated	☐	+ not treated	Not done, explain:
Other	☐	Negative	☐	+ treated	☐	+ not treated	Specify:

Women Only							
Female Circumcision	☐	Yes	☐	No	☐	Explain:	
Pregnancy Test	☐	Positive	EDC: / /		☐	Not done, explain:	
	☐	Negative	LMP: / /				

Name : (Last, First Middle)		Alien #:	

Section XII	**Referrals**		
Primary Care **REQUIRED**	Name:	Phone:	
	Address:	Appt: / /	a.m. / p.m.
Dental	Name:	Phone:	
	Address:	Appt: / /	a.m. / p.m.
Other	Referred for:	Specialty:	
	Name:	Phone:	
	Address:	Appt: / /	a.m. / p.m.
Other	Referred for:	Specialty:	
	Name:	Phone:	
	Address:	Appt: / /	a.m. / p.m.
Other	Referred for:	Specialty:	
	Name:	Phone:	
	Address:	Appt: / /	a.m. / p.m.
USCIS Civil Surgeon	Name:	Phone: **Civil Surgeon Referral is Required**	

AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH INFORMATION (PHI)

I, (Refugee Name) _____, hereby authorize (Provider) _____ to release my health screening information to the Ohio Department of Job and Family Services, Refugee Services Program in order to facilitate invoicing, continuity of care and the refugee health demographic data collection.

The PHI is to be mailed to:
Ohio Refugee Services Program
ODJFS Office of Family Stability
P.O. Box 182709
Columbus, OH 43218-2709

The specific protected health information to be released is:
This Refugee Health Screening form (JFS 01460), and any other information determined to be necessary on processing my initial health screen payment to (Provider) _____.

By Signing below I understand that:

- This authorization shall expire 90 days from date of service or until revoked by me in writing, whichever comes first.
- I have the right to revoke or cancel this authorization at any time by providing notice in writing to this office.
- If I revoke or cancel this authorization, it is not effective for the use or disclosure of my PHI that has already occurred.
- I have the right to inspect or copy the PHI that will be used or disclosed as per authorization.

Signature: Refugee or Authorized Representative/Parent/Guardian	Print: Refugee or Authorized Representative/Parent/Guardian	Date
Signature: Witness	Print: Witness Name	Date
Signature: Provider Representative	Print: Provider Representative	Date

_____ (Initials) Patient acknowledges receiving advice and understanding patient's rights, responsibilities, privacy practices and has been offered a copy of notice of privacy practices.