

Kansas Refugee Health Assessment Form

REQUEST FOR PAYMENT: Refugee Health Coordinator, KDHE, 1000 SW Jackson, Suite 340, Topeka, KS 66612-1365

Name: Last _____ First _____ MI _____

"A" Number: _____ Social Security Number _____

Address: _____

Sex: ___ DOB _____ Arrival Date _____ Country of Origin _____ USPHS Class _____ KS County: _____

Language: _____ Assessment _____

Health Assessment Status: Incomplete Private Health Care Moved Refused Lost to Follow-up
 Date Completed _____
 Medicaid # _____

Provider Signature _____ Date _____

HEALTH ASSESSMENT

HEALTH HISTORY:(OTHER SIDE) Complete: YES NO INTERPRETER _____

LABORATORY AND SCREENING:

TEST	DATE	FINDINGS	Referral	Referral Date
TB SKIN TEST OR IGRA (CHECK BOX) <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
HGB/HCT			YES <input type="checkbox"/> NO <input type="checkbox"/>	
CBC (Recommended)			YES <input type="checkbox"/> NO <input type="checkbox"/>	
HIV (> 12 yrs age)			YES <input type="checkbox"/> NO <input type="checkbox"/>	
HEP B (HBsAg)			YES <input type="checkbox"/> NO <input type="checkbox"/>	
URINALYSIS			YES <input type="checkbox"/> NO <input type="checkbox"/>	
OVA/PARASITES			YES <input type="checkbox"/> NO <input type="checkbox"/>	
HEARING			YES <input type="checkbox"/> NO <input type="checkbox"/>	
VISION			YES <input type="checkbox"/> NO <input type="checkbox"/>	
LEAD SCREENING (6 months – 16 years of age) Follow-up Lead (< 6 yrs age w/in 3-6 months of initial screen)			YES <input type="checkbox"/> NO <input type="checkbox"/>	

PHYSICAL EXAMINATION: (OTHER SIDE)

Physical Exam Complete: YES NO or NA Weight: _____ Height: _____ BP _____ Referred? YES NO

IMMUNIZATIONS:(Vaccine must be age-appropriate and recommended by ACIP)

IMMUNIZATION SERIES				IMMUNIZATION SERIES			
Infant/Child		Given After Arrival	# Before	Adult		Given After Arrival	# Before
		Date	US Arrival			Date	US Arrival
DTaP /DT	1 2 3 4 5			Td	1 2 3		
Tdap	1 2			Td/Tdap (Booster every 5 to 10 years)	1		
IPV/OPV	1 2 3 4 5			MMR	1 2		
MMR	1 2			Adult Varicella	1 2		
Varicella	1 2			Influenza	1		
Influenza	1			Pneumococcal	1		
Pneumococcal	1			Hepatitis A	1 2		
Hepatitis A	1 2			Hepatitis B	1 2 3		
Hepatitis B	1 2 3			HPV(Optional)	1 2 3		
HPV(Optional)	1 2 3			Meningococcal	1		
Meningococcal	1			Zoster (Optional)	1		
HIB	1 2 3 4			Other			
Rotavirus	1 2 3						

ADDITIONAL TB INFORMATION:

TB CHEST X-RAY - Ordered: _____ COMPLETED _____ FINDINGS _____
 DATE _____ DATE _____

TB Medicines? YES NO Pending IF YES, Date Started: _____

OTHER REFERRALS:

Dental: Medical: ER/Urgent Care: Mental Health: Child Health: Perinatal Care:
 WIC: Family Plan: Medicaid/RMA: Mammogram: Other: _____

KDHE REPORT KANSAS REFUGEE HEALTH ASSESSMENT (Continued)

Name: _____ "A" Number: _____

HEALTH HISTORY

IN THE LAST YEAR:

✓CHECK ALL THAT APPLY

<input type="checkbox"/>	FEVER	<input type="checkbox"/>	JAUNDICE
<input type="checkbox"/>	COUGH	<input type="checkbox"/>	NIGHT SWEATS
<input type="checkbox"/>	DIARRHEA	<input type="checkbox"/>	RASH
<input type="checkbox"/>	HEADACHES	<input type="checkbox"/>	VOMITING
<input type="checkbox"/>	HEMOPTYSIS	<input type="checkbox"/>	WEIGHT LOSS

ALLERGIES _____

MEDICINES _____

MEDICAL PROBLEMS _____

INJURIES/ACCIDENTS _____

SURGERY _____

RECENT FAMILY ILLNESS _____

FOR WOMEN	CHILDREN AGES 0-6 YEARS
LMP _____ FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>	PLACE OF BIRTH: _____
# PREGNANCIES _____ Last PAP TEST _____ Date _____	PROBLEMS AT BIRTH: _____
LIVE BIRTHS _____ Last BREAST EXAM _____ Date _____	CHILDHOOD DISEASES: _____
LIVING CHILDREN _____ PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/>	

Not Done: NA Normal: N Abnormal: A 1. General Appearance _____ 2. Head _____ 3. Eyes _____ 4. Ears _____ 5. Nose _____ 6. Oral Cavity (Dental) _____ 7. Pharynx _____ 8. Neck _____ 9. Lymph Nodes _____ 10. Cardiovascular _____ 11. Chest _____ 12. Lung _____ 13. Breast _____ 14. Abdomen _____ 15. Skin _____ 16. Male Inguinal Hernia _____ Female-Pap Smear _____ 17. Neurological _____ 18. Musculoskeletal _____	PERTINENT FINDINGS

PHYSICAL EXAMINATION ASSESSMENT AND PLAN:

EXAMINER'S SIGNATURE _____ DATE _____