

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 _____ Date Completed _____

Health Assessment Status: Incomplete Private Health Care Moved Refused Lost to Follow-up 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			YES <input type="checkbox"/> NO <input type="checkbox"/>	
HGB/HCT			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"/>	
HEP B (HBsAg)			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)			YES <input type="checkbox"/> NO <input type="checkbox"/>	
FOLLOW-UP LEAD (under 6 yrs age-w/in 3-6 mos of initial screening)			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:

IMMUNIZATION SERIES	Given After Arrival	# Before	IMMUNIZATION SERIES	Given After Arrival	# Before
Infant/Child	Date	US Arrival	Adult	Date	US Arrival
DTaP 1 2 3 4 5			Td 1 2 3		
DPT 1 2 3 4 5			Td/Tdap (Booster every 5 to 10 years)		
Tdap 1 2			MMR 1 2		
IPV/OPV 1 2 3 4 5			Adult Varicella 1 2		
MMR 1 2			Influenza		
Varicella 1 2			Pneumonia		
Hepatitis B 1 2 3			Other		
HIB 1 2 3 4					
Hepatitis B 1 2 3					
Rotavirus 1 2 3					
PCV7					
Influenza					

ADDITIONAL TB/HEPATITIS INFORMATION:

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

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

Hepatitis B: Number of household contacts: # _____ Number of contacts treated: # _____

OTHER REFERRALS:

Dental: Medical: ER/Urgent Care: Mental Health: Child Health: Perinatal Care:

WIC: Family Plan: medicaid/RMA: Mammogram: Other: _____

