KANSAS REFUGEE HEALTH PROGRAM MANUAL

Revised – January 2013

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
KANSAS REFUGEE HEALTH PROGRAM
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TOPEKA, KS 66612-1365
785-296-1200

Kansas Refugee Health Program Manual

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KANSAS REFUGEE HEALTH ASSESSMENT PROTOCOL

INTRODUCTION

This document, describing the administrative/clinical services, procedures for health screenings, preventative services has been revised in 2013 by the Refugee Health Program (RHP), Bureau of Community Health Systems, Kansas Department of Health and Environment for refugee health assessment providers. The following guideline for health assessment of refugees in Kansas has been developed in collaboration with the Office of Refugee Resettlement (ORR) and the Division of Global Migration Quarantine, Centers for Disease Control and Prevention (CDC), and State Refugee Health Coordinator.

The purposes of the refugee health screening are as follows:

- To ensure follow-up (evaluation, treatment and/or referral) of medical issues and Class A and B conditions (see appendix) identified during the overseas medical exam
- To identify persons with communicable diseases of potential public health importance
- To enable a refugee to successfully resettle by indentifying personal health conditions that, if left unidentified, could adversely impact his or her ability to resettle (e.g., job placement, language training, or attending school); and
- To refer refugees to primary care providers for ongoing health care.

For effective health screening the following principles should be incorporated:

- Be accessible to the client
- Be supported by effective data systems
- Be flexible
- Be sensitive to cultural issues
- Utilize a variety of community resources

The RHP utilizes the following objectives to address the purposes outlined above:

- A health assessment will be completed within 60 days on 90% of refugees identified as primary arrivals or of secondary arrivals. Follow-up will be done on all known arrivals not complying with the health assessment.
- Referral of 95% refugees with health problems significant to public health or that impedes resettlement and self-sufficiency will be made within 30 days of problem identification.
- Referrals of 95% of refugees are made to primary care.

DESCRIPTION OF THE HEALTH ASSESSMENT

The initial health assessment should be initiated within 30 days of arrival, not to exceed 90 days for completion. For non-English speaking refugees, a qualified interpreter should be available during all clinic appointments (Civil Rights Act Title VI, 1964). For more information and resources regarding this requirement refer to ***Appendix A-Interpreter Code of Ethics*** and http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html

A complete refugee health assessment consists of the following:

- Review of health history
- Laboratory screening or presumptive treatment for certain medical conditions
- Physical examination performed by a physician, physician assistant, or a nurse practitioner
- Immunizations or serology testing for immunity
- Referrals for identified health conditions and primary care

In order to assure effective resettlement of new refugees, the voluntary resettlement agencies (VOLAGs) or local sponsors are requested to notify the local identified refugee health assessment provider and arrange an appointment for a health assessment within the first two weeks of arrival. Expedient health assessment appointments are recommended for all refugees but those with a Class A or Class B conditions require immediate evaluation. A referral system of urgent medical and mental health care for new refugee arrivals, who have not had time to gain entrance into the health care system, should be developed at each local refugee health assessment provider. The State Refugee Health Coordinator will be available to the local provider and VOLAG for consultation on referrals and follow-up as appropriate.

The health assessment encounter is the first contact refugee(s) will have with the Kansas health care system and is an opportunity for referrals to appropriate continuing care. The majority of new refugee arrivals will qualify for Medicaid/Refugee Medical Assistance for the first eight months after their arrival date into the United States. Therefore it is important to encourage the refugees to receive all preventive health services possible that will assist them to regain and maintain healthy lives. Health education in the native language of the refugee (written or through an interpreter), information about the local community health resources, and information on accessing the health care system should be an integral part of the initial assessment encounter.

All health providers should understand and be sensitive to the physical and psychological trauma refugees have experience in the migration process. Questions on sensitive issues such as torture, rape or family violence should be

reserved for trained experts in a setting of a trusting relationship. Refugees may have been subjected to multiple stressors before migrating, while in flight, and in many cases, during a temporary or even long resettlement period prior to their arrival in the U.S. The evaluation of mental health needs of refugees is a critical part of the initial assessment encounter and can serve as an opportunity to briefly educate refugees during resettlement about some of the psychosocial difficulties they may experience and the community mental health and social service resources available. Appropriate mental health referrals and consultation should be sought when indicated.

OVERVIEW OF CORE SCREENING AND REFERRAL PROCEDURES

All refugees and overseas applicants for a United States immigrant visa must undergo a medical examination prior to embarking for the United States. The standards for this screening are established by the United States Centers for Disease Control (CDC), National Center for Infectious Disease, Division of Quarantine. Refugees receive instructions during their initial overseas orientation to bring copies of their international physical examination record on the DS-2053 or DS-2054 "*Medical Examination for Immigrant or Refugee Applicant*", DS-3024 or DS-3030 "*Chest X-Ray and Classification Worksheet*", DS-3025 "*Vaccination Documentation* Worksheet", and DS-3026, "*Medical History of Physical Examination Worksheet*". The history should also include a review of the UNHCR Medical Assessment Form (MAF), the International Organization for Migration's Significant Medical Conditions (SMC) form and Pre-Departure Medical Screening (PDMS) form, immunization records and other individually carried documents. This information has also been sent directly to the Kansas State Health Department from through the **U.S. Centers for Disease Control and Prevention *Electronic Disease Notification*** system and is available upon request.

RECOMMENDATIONS:

When refugees present for their domestic health assessment, providers should verify the correct spelling of all names, refugee alien visa number (begins with A and has eight digits), date of birth, country of origin, and date of arrival in the United States. This information can be found on the DS-2053 or DS-2054 and also on refugees' I-94. An I-94 card, 'Arrival/Departure Record,' proves a refugee/asylee's legal status in the U.S. Refugees receive I-94s (see example below) when entering the U.S. for the first time at the port of entry from Customs and Border Patrol (CBP), Department of Homeland Security. Asylees who have been granted asylum from the U.S. Citizenship and Immigration Services (USCIS), Department of Homeland Security are issued an I-94 with their asylum approval letter.

When initiating the assessment all refugees should sign consent for care and release of information (preferably in their own language) before services are rendered, according to local clinic procedures. If the client is non-English speaking and the forms are not translated into his or her primary language, the consent should be interpreted to the client and the interpreter should sign the note.

General Refugee Health Guidelines developed through the Centers for Disease Control and Prevention (CDC) should be reviewed before performing refugee assessments. They are available at http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html.

REVIEW:
Cultural factors may limit an uninhibited and free exchange of health history. A complete review of the following documents, if available, is important to augment the health history:

- DS-2053 or DS-2054 "*Medical Examination for Immigrant or Refugee Applicant*",
- DS-3024 or DS-3030 "*Chest X-Ray and Classification Worksheet*",
- DS-3025 "*Vaccination Documentation* Worksheet", and DS-3026, "*Medical History of Physical Examination Worksheet*",
- UNHCR Medical Assessment Form (MAF),
- International Organization for Migration's Significant Medical Conditions (SMC) form, and
- Pre-Departure Medical Screening (PDMS) form

CDC's ***Domestic Examination for Newly Arrived Refugees: Guidelines and Discussion of the History and Physical Examination*** should be reviewed before performing refugee assessments at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/guidelines-history-physical.html.

EVALUATION:

Health History:
Question for recent fever, diarrhea, cough, weight loss, night sweats, hemoptysis, other recent illness in self or family, known medical problems (including medications, allergies)

Provide evaluation, additional tests or referral for primary health services and/or treatment, as indicated for:

Class A and B Conditions: Follow-up (evaluation, referral for treatment) of Class A and B conditions indentified during the overseas medical exam and reported on the DS 2053 or DS 2054. The overseas medical exam identifies physical and mental health problems of public health significance. Health problems are designated as Class A or Class B conditions. See ***Appendix B-CDC Communicable Disease of Public Health Significance*.** Class A conditions are those that may potentially preclude immigration to the United States. (HIV disease is no longer a Class A condition and there is no routine testing of HIV in the overseas examination.) Active pulmonary TB or positive tests for syphilis are supposed to be fully treated before being allowed to travel to the United States. These conditions, once treated are considered Class B conditions. Class B conditions are those that represent such significant health problems that they must be brought to the attention of consular authorities and that should be address soon after arrival in the United States.

Screening and Laboratory:
Tuberculosis: Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) should be given regardless of a history of BCG vaccination. Either a TST or IGRA is acceptable for adjustment of immigration status for testing of refugees for Tuberculosis. If the TST or IGRA is positive complete the KDHE Latent Tuberculosis Infection and Disease form located at http://www.kdheks.gov/tb/index.html and submit to the local county health department.

A chest x-ray is required if the TST or IGRA is positive. If the refugee has a positive TST or IGRA and is symptomatic for TB i.e. productive cough, night sweats, etc. to rule out disease, 3 sputum need to be collected according to CDC recommendations. If any of the above applies a timely referral needs to be made so that a diagnosis can be made and appropriate treatment initiated. Always call the TB Control & Prevention Program whenever there is a suspicion that the refugee could have TB disease because of symptoms or abnormal chest x-ray. For more information on TB classifications and follow up refer to ***Appendix C-Specific Follow-up Recommendations for Tuberculosis B1 and B2 TB Classifications***.

For more information refer to CDC's ***Guidelines for Screening for Tuberculosis Infection and Disease during the Domestic Medical Examination for Newly Arrived Refugees*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html

Complete Blood Count: (required)

HIV Testing: HIV will be conducted using conventional HIV (blood draw) testing with refugee clients through existing Counseling and Testing site locations. All refugee clients, age 13 and over, who have not received an HIV test during their overseas exam may be tested for HIV. For more information or questions contact the KDHE HIV Counseling, and Testing Program (316) 218-5797. All Conventional HIV (blood draw) testing will be submitted to the Department of Health & Environment Labs for processing. Lab specimens should be sent to:

KDHE Labs
Bldg. 740, Forbes Field
Topeka, Ks 66620

HIV tests conducted for refugee clients should not be entered into EvaluationWeb unless the refugee client has a confirmed HIV positive test result, only then should the positive HIV testing data be entered into EvaluationWeb. Additionally, an Adult Case Report Form should be completed and submitted to KDHE within 7 days of the test. When an HIV Test is completed for a refugee client the Department of Health and Environment Lab number / barcode sticker will be placed on the. For copies of the Refugee testing Log please contact the KDHE HIV Counseling, and Testing Program (316) 218-5797. Agencies will follow all set KDHE protocols and procedures for reporting confirmed positives to DIS and Linkage to Care. KDHE should be notified immediately when a confirmed positive is identified.

Read more in depth information regarding screening in CDC's ***Screening for HIV Infection during the Refugee Domestic Medical Examination*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html

Sexually Transmitted Diseases: Syphilis continues to be included in the overseas refugee medical exam and all identified STD's will be identified on the DS 2053 or DS 2054. For the domestic refugee health assessment, a complete screening medical examination for all STIs includes a thorough medical history, physical examination and, for specific disorders, diagnostic testing. Although history taking is challenging due to language and cultural barriers, the optimal medical history should include inquiries regarding sexual contact with a person

who has or had a known STI or symptoms of an STI, signs and symptoms of current infection (e.g., genital discharge, dysuria, genital lesion, ulcer, or rash), and/or prior diagnostic evaluation and treatment of STIs. Information on treatment of sex partners should be obtained to assess risk of re-infection. Any questions or inquires concerning syphilis or any STD should be referred to the local DIS or directly to the state STD Control Program (785) 296-5596.

Refer to CDC's ***Screening for Sexually Transmitted Disease during the Domestic Medical Examination for Newly Arrived Refugees*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html

Hepatitis B: HBsAg testing of all refugees who are from or have resided in countries with intermediate (>2%-7%) or high (>8%) prevalence of chronic HBV infection should be included in the assessment. All HbsAg-positive person should receive appropriate counseling and be evaluated for treatment. Asymptomatic refugees who do not originate from or have not resided in countries where chronic HBV prevalence is either intermediate or High should undergo screening with serologic testing if they are considered at increased risk according to CDC guidelines. Identification of carriers with subsequent testing of household contacts for Hepatitis B immunity is good public health practice. To determine if the positive HbsAg is an acute or chronic case, use the CDC Viral Hepatitis Case Report questions under Clinical Data. An acute case is hepatitis B surface antigen (HbsAg) positive, with discrete onset of symptoms and jaundice or elevated liver enzymes. Acute cases are reportable to the KDHE Office of Epidemiologic Services. After identifying a positive test for Hepatitis B on an initial screening, it is important to determine the immunity status of household contacts and provide vaccine for susceptible individuals. Call the KDHE Office of Epidemiologic Services 785-296-2951 for Hepatitis information or questions.

For more information refer to CDC's ***Screening for Viral Hepatitis during the Refugee Domestic New Arrival medical Examination*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/viral-hepatitis.html

Urinalysis

Ova / Parasites: Screening guidelines are based on the refugee's point of departure for the United States and whether the refugee received pre-departure presumptive therapy. Records of presumptive treatment received by the refugee are available in the IOM or Blue and White bag carried by the refugee or if unavailable, check with the State Refugee Health Coordinator for information through the Electronic Data Network (EDN). If documentation of treatment is not available it should be assumed the refugee did not receive presumptive therapy.

Presumptive treatment for strongyloides and schistosomiasis should be prescribed. An eosinophil count should be routinely performed as part of the domestic medical screening examination. An absolute eosinophil count of >400 cells/mL is considered elevated. IF a refugee has an elevated eosihophil count treatment or a re-check in 3-6 months is indicated.

For more information refer to CDC's ***Domestic Intestinal Parasite Guidelines*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html

Malaria: Refugees from malaria endemic areas in sub-Saharan Africa should receive presumptive therapy for malaria. Refugees who have received a pre-departure treatment with a recommended ant malarial drug or drug combination do not need further evaluation for treatment for malaria unless they have clinical symptoms. It is recommended that refugees originating in sub-Saharan Africa who have not received pre-departure receive presumptive treatment on arrival.

For more specific and in depth information refer to CDC's ***Malaria: Domestic Guidelines*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html

Lead: A blood lead level test must be administered to all children less than five (5) years of age upon entering Kansas. Blood lead level results are required to be submitted to the Kansas Department of Health and Environment (KDHE) Bureau of Epidemiology and Public Health Informatics for surveillance purposes. Physicians and local public health departments may be able to provide follow up or support services for those children with elevated lead levels. If a child is eligible for Medicaid/KanCare, coordination of health care benefits will be made through the benefits provider. The KDHE Bureau of Environmental Health can assist local health departments and families with information about the causes and ways to prevent lead poisoning in Kansas.

For more information refer to CDC's ***Refugee Health Guidelines: Lead Screening*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html

Nutrition and Growth:
The main goal of nutritional status screening of refugees after arrival is to identify those with nutritional deficiencies that require further evaluation and/or treatment. Adequate medical follow-up and continuity of care after initial screening are essential to ensure identification of nutritional and other health issues, monitor growth and development, as well as to provide preventive services and education. In addition, refugees are particularly vulnerable after arrival and may not

understand the complex health and social safety net to assure access to food, enrollment in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and food stamps, may be essential.

For more information refer to CDC's ***Guidelines for Evaluation of the Nutritional Status and Growth in Refugee Children during the Domestic Medical Screening Examination*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/nutrition-growth.html

Immunizations:
Refer to the Advisory Committee on Immunization Practices (ACIP) for the general U.S. population to decide which vaccines will be required for U.S. immigration. Vaccination criteria are based on age-appropriateness, protect against a disease that can cause an outbreak and/or protect against at disease that has or is in the process of being eliminated in the United States. *(Zoster and HPV vaccinations are not required.) For more information on immunization recommendations related to age and risk groups refer to* http://www.cdc.gov/vaccines/recs/schedules/default.htm or ***Appendix D - Immunization Schedule for Children, Adolescents and Adults***.

Read CDC's ***Evaluating and Updating Immunizations during the Domestic Medical Examination for Newly Arrived Refugees*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/immunizations-guidelines.html

Adult Tdap and MMR are covered by the KDHE Immunization Program (see ***Appendix E-Kansas Immunization Program Memorandum***) and should be listed on the monthly KDHE Immunization Report (MRI) located at http://www.kdheks.gov/immunize/vfc_reporting.htm .

All other antigens must be provided through private stock. All refugee immunizations provided after the refugee health assessment is completed should be billed to Medicaid (if refugee is covered) or self-pay.

When refugees apply to adjust their immigration status (typically one year after arrival in the United States) they must provide proof of receipt of required immunizations documented on the I-693 form found at http://www.uscis.gov/files/form/I-693.pdf. For refugees (who did not have a Class A condition) physicians at local public health departments may act as a civil surgeon and sign the I-693 to document immunizations. Directions on completing the I-693 can be found at http://www.uscis.gov/files/form/i-693instr.pdf.

Physical Examination:

The physical exam should involve a comprehensive clinical evaluation as well as a head-to-toe review of all systems (including heart, lungs, ENT, skin evaluation), gross evaluation of vision and hearing, height, weight, blood pressure. Refer to primary care for further evaluation (preferably to a health care facility that will ultimately provide routine care) if any screening tests or physical exam findings are significantly abnormal and/or for routine medical care. (See ***Find a Clinic*** at the KAMU Primary Care Association of Kansas website http://kamuonline.org for listing of medical and dental clinics).

Dental Screen: Gross evaluation (age two and over). Refer all refugees to dental care for routine or follow up oral health needs. (See ***Find a Clinic*** at the KAMU Primary Care Association of Kansas website http://kamuonline.org for listing of medical and dental clinics).

Behavioral Health: General assessments of orientation to place, date, and time (mental status). Providers should be aware and recognize symptoms of mental illness, and conditions that negatively affect the refugee's ability to adjust. Referral for mental health or substance abuse are given when symptoms of mental illness, signs or histories of torture or abused that negatively affect the refugees ability to adjust are suspected or recognized (See Kansas Department for Aging and Disability Services to identify **mental health services** in your area to refer to at *http://www.kdads.ks.gov/CSP/MH_Services_Index.html*).

For more in depth information, refer to CDC's ***Guidelines for Mental Health Screening during the domestic Medical Examination for Newly Arrived Refugees*** at http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html

See ***Appendix F-ORR's Domestic Medical Screening Guidelines Checklist*** for helpful and concise assessment components.

Referrals: Refer all refugees to a primary care provider for on-going preventive care (including those listed above) and to establish a medical home. Referrals to federally funded Community Health Centers and state supported primary care clinics are encouraged especially for those adult refugees that may be or become uninsured (See (See ***Find a Clinic*** at the KAMU Primary Care Association of Kansas website http://kamuonline.org for listing of medical and dental clinics). Refer refugees to all other available and appropriate public health programs (Women, Infant and Children (WIC), Family Planning, Early and Periodic Screening Diagnosis and Treatment (Kan-B-Healthy), Breast and Cervical Cancer Screening (Early Detection Works). When making referrals provide refugees with provider names, phone numbers, and directions.

Additional Age Specific Screening Recommendations

Some testing recommendations related to age may need to be added or adjusted based on health history, prior laboratory results, cultural mores, and/or professional judgment.

Children less than 5 years of age

- Core elements as identified previously
- Head Circumference
- Screening for developmental milestones

Children 5-15 years of age

- Core elements as identified previously
- Developmental level/mental status evaluation
- Nutritional evaluation if height, weight less than 5th percentile
- Evaluation for hypertension if blood pressure is elevated.
- CBC indices, lead level, malaria smear if hematocrit less than 30 percent
- Testing for sickle cell, thalassemia, or Tay Sachs
- Chest x-ray if PPD or IGRA positive
- DRL if indicated (by history or abnormal exam)

Refugees 16 years and above:

- Core elements as identified previously
- All females between 16 and 50:
    - Pregnancy test if indicated
- Pap smears for sexually active women and all women more than 40 years.

Additional screening tests or referral to primary health services (age 16-adult) when indicated by history or initial assessment.

- Further evaluation if weight greater than 10% under or greater than 40% over normal range
- Evaluation for hypertension if blood pressure is elevated,
- CBC indices, sickle cell prep (or hemoglobin electrophoresis), malaria smear if hematocrit less than 30%.

Adults 46 years of age and above:

- Stool exam for blood (hemoccult)
- Fasting glucose, cholesterol
- Cancer information and referral for further evaluation as appropriate
- Mammogram and breast exam for women more than 50 years.

INSTRUCTIONS FOR COMPLETION OF THE KANSAS REFUGEE HEATLH ASSESSMENT FORM

The Kansas Refugee Health Assessment (KRHA) is designed for the documentation of the initial refugee health assessment completed in the local health department and to provide the State refugee health data required by the Office of Refugee Resettlement. The front page of the KRHA contains a block for REQUEST FOR PAYMENT which will be used for billing procedures as well as providing the documentation and demographic data required by the Preventive Refugee Health grant. The health history and physical examination are on the back of the KRHA. When the local health provider receives notification from the local resettlement agency of a refugee or asylee arriving in Kansas and in need of a refugee health assessment, the following identification information (name, A number, sex, date of birth, abbreviation of country of origin, USPHS class (if present) and country) should be completed on the KRHA. When the refugees come for the health assessment and the overseas examination documentation is presented, the remainder of the form is completed. The original copy stays in the local health department. When completed the copy of the front page of the KRHA which is also the billing document, is sent to:

REFUGEE HEALTH PROGRAM COORDINATOR
KANSAS DEPARTMETN OF HEALTH AND ENVIRONMENT
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

Refugee health assessments may be reimbursed if completed no later than eight months from their arrival date in the United States. However assessments should be started within the first thirty days and completed within two months of the date of entry if at all possible. If the assessment is not completed in this timeframe, please document the reason.

SPECIFIC INSTRUCTIONS

Request for Payment:
Name: (Required for billing). Clearly write the full name as it appears on the CDC Health Information form (or equivalent). If there is a correction in the spelling of the name from that on the CDC Information form, please correct and note that the name was rewritten on the KRHA. This procedure will eliminate duplication of names.

A Number: (Required for billing): Enter the eight-digit Alien-number found on the CDC Enter Information form or the I-94.

Social Security Number: (required on refuges of secondary resettlement)

Address: Enter the actual address where the refugee lives at the time of the visit. If there are anticipated changes these can be noted in the comments for future reference.

Sex: Enter gender of the person. It may be difficult to discern gender with some international names.

DOB: (Required for Billing) If possible obtain the birth date from the immigration documents. Many times the date is unknown and an estimated date is assigned. Ask the refugee for this information to verify the correct date.

Arrival Date: (Required for Billing). Record the date the refugee arrived in the USA found on the I-94 or CDC Health Information form.

Country of Origin: Use the two letter country abbreviations of the country of birth. (See ***Appendix G- Country Code Table Abbreviations***)

USPHS Class: The USPHS Class is the health condition assigned by the quarantine station upon arrival into the USA. It will be a Class A or Class B condition (see ***Appendix B-US Public Health Service Classifications: Class A and Class B Conditions***). If no classification is given, leave blank.

KS County: (Required for Billing.) Fill in the abbreviation of the country where the assessment is performed.

Language: Record the principal language spoken by the client.

Date Completed: (Required by Billing.) Record the date the health assessment was completed in the blank after assessment. If only part of the assessment was completed or the client refused certain segments of the assessment and the service is not billed by the health department, check the box in the following line after status-incomplete. If no services were rendered, do not fill in this space but proceed to the next line (assessment status) and check the appropriate item.

Assessment Status: Check appropriate box for the reason the assessment was not started or completed.

Medicaid#: If he or she has a Medicaid number enter the number into the space.
Provider Signature: (required for Billing.) The person completing the Health Assessment should sign his or her name and professional title and date signed.

It is recommended that all refugee health assessments (a copy of the front page) done in the months should be sent to KDHE by the last day of that month. This will assist in reasonable payment turnaround time.

Health History: Circle the appropriate answer on the complete of the health history. The health history is recorded on the back.

Laboratory and Screening: Record the date the lab/screening was started in the date column. When the results are available, record them in the findings column. Check either the yes or no box if a referral was made for the screening and referral date in the appropriate last columns. Note: If laboratory tests are significantly delayed and will interfere with timely billing and data processing please contact the KDHE refugee health coordinator for direction.

Physical Examination: Check the appropriate answer for the completion of the physical examination, which is recorded on the back and referrals, if made, based on the health provider examination and assessments. Enter the weight (wt.), height (ht), and blood pressure (BP) in the blanks.

Immunizations: Record the immunization information in the appropriate boxes. If immunizations were given before arrival, document in the "# Before US Arrival" box. If immunizations are given by the local health department, record the date in the "Given After Arrival" columns. There are two areas after each immunization to allow for recording of vaccinations administered during and after the physical assessment period.

Additional TB Information: If done, enter the date the TB x-ray was ordered. Record the date the x-ray was completed and the findings in the next two spaces, if known. If ordered, but results are not back at the completion of form, the information can be added later. If TB medicines are prescribed, check the appropriate answer. If yes, enter the starting date. If referred to a physician for prescription but not on medicines at the time of completion, check pending.

Other Referrals: Check all of the appropriate boxes of referrals made.

Health History

Check boxes of any of the listed symptoms the client has experienced in the last year. On the right, record any conditions the client has had in the past or present. Under recent illness in family, record any conditions that indicate a communicable health condition or condition that will affect the family's resettlement.

Box for Women and Children

Note or check appropriate information on females in the "For Women" box, and "Children Ages 0-6" box, record country or location of birth if available. Record

any information the parent may be able to provide concerning conditions at birth. Record any childhood disease and include malaria, or other communicable disease reported. Upon completion, check appropriate box under “health history”, page 1.

Physical Examination

Record the appropriate code for each area examined on the left and any pertinent findings on the right side. Upon completion, check the appropriate boxes under “Physical Examination”, page 1. Check the referral appropriate referral boxes based on the physical examination.

Assessment and Plan

Write the assessment and care plan in the area under the physical examination box. The health professional completing the physical examination signs at the check mark and records the date the physical examination was completed.

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 OR IGRA (CHECK BOX) ☐			YES ☐ NO ☐	
HGB/HCT			YES ☐ NO ☐	
CBC (Recommended)			YES ☐ NO ☐	
HIV (> 12 yrs age)			YES ☐ NO ☐	
HEP B (HBsAg)			YES ☐ NO ☐	
URINALYSIS			YES ☐ NO ☐	
OVA/PARASITES			YES ☐ NO ☐	
HEARING			YES ☐ NO ☐	
VISION			YES ☐ NO ☐	
LEAD SCREENING (6 months – 16 years of age) Follow-up Lead (< 6 yrs age w/in 3-6 months of initial screen			YES ☐ NO ☐	

PHYSICAL EXAMINATION: (OTHER SIDE)
Physical Exam Complete: **YES ☐ NO ☐ or NA ☐** ***W***eight:_____ ***H***eight:_____ ***BP***_____ Referred? **YES ☐ NO ☐**

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

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

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

ADDITIONAL TB INFORMATION:
TB CHEST X-RAY - Ordered:_____COMPLETED_____FINDINGS_____
DATE DATE
TB Medicines? **YES ☐ NO ☐ Pending ☐** IF YES, Date Started:_____

OTHER REFERRALS:
Dental: ☐ Primary Care/Medical Home: ☐ ER/Urgent Care: ☐ Behavioral Health: ☐ Child Health: ☐ Perinatal Care: ☐
WIC: ☐ Family Plan: ☐ Medicaid/RMA: ☐ Disability Services: ☐ Other: ☐_____

KDHE REPORT **KANSAS REFUGEE HEALTH ASSESSMENT (Continued)**

Name:_____ "A" Number:_____

HEALTH HISTORY

IN THE LAST YEAR:
✓CHECK ALL THAT APPLY

	FEVER		JAUNDICE
	COUGH		NIGHT SWEATS
	DIARRHEA		RASH
	HEADACHES		VOMITING
	HEMOPTYSIS		WEIGHT LOSS

ALLERGIES _____

MEDICINES _____

MEDICAL PROBLEMS _____

INJURIES/ACCIDENTS _____

SURGERY _____

RECENT FAMILY ILLNESS _____

FOR WOMEN	**CHILDREN AGES 0-6 YEARS**
LMP_____ FAMILY PLANNING YES ☐ NO ☐ # PREGNANCIES_____ Last PAP TEST_____ Date LIVE BIRTHS_____ Last BREAST EXAM_____ Date LIVING CHILDREN_____ PREGNANT? YES ☐ NO ☐	PLACE OF BIRTH:_____ PROBLEMS AT BIRTH:_____ CHILDHOOD DISEASES:_____

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_____

Updated 1/1/13

ADJUSTMENT OF STATUS PROCESS AND MEDICAL EXAMINATION

Refugees are eligible to apply for adjustment of status to become a legal resident after one year in the United States. While most immigrants are required to have a full medical examination at the time of applying for adjustment of status, refugees are an exception. Refugees who arrived without a Class A condition only require vaccinations with their adjustment of status; the full medical examination is not required. A full medical exam is only required for refugees if a Class A condition existed prior to arrival in the US. This full medical exam is performed by a Civil Surgeon. Civil Surgeons are designated by the District Director of the United States Citizenship and Immigration Services (USCIS). If only the vaccination assessment is necessary for refugees, this may be performed by either a Civil Surgeon or local public health. For a listing of Civil Surgeons in Kansas go to https://egov.uscis.gov/ to the USCIS Civil Surgeons Locator.

Thank you for providing refugee health assessments in your area and in assisting refugees to start their new life in the United States in good health. If you have questions regarding the information contained in this manual or about refugee health in general, please contact Cyndi Treaster, State Refugee Health Coordinator, at ctreaster@kdheks.gov or call (785) 296-8113.

APPENDICES

Interpreters Code of Ethics

Confidentiality
Interpreters must treat all information learned during the interpretation as confidential, divulging nothing without the full approval of the client and his/her provider.

Accuracy: Conveying the Content and Spirit of What is Said
Interpreters must transmit the message in a thorough and faithful manner, giving consideration to linguistic variations in both languages and conveying the tone and spirit of the original message. A word-for-word interpretation may not convey the intended idea. The interpreter must determine the relevant concept and say it in language that is readily understandable and culturally appropriate to the listener. In addition, the interpreter will make every effort to assure that the client has understood questions, instructions and other information transmitted by the service provider.

Completeness: Conveying Everything that is Said
Interpreters must interpret everything that is said by all people in the interaction, without omitting, adding, condensing or changing anything. If the content to be interpreted might be perceived as offensive, insensitive or otherwise harmful to the dignity and well-being of the patient, the interpreter should advise the health professional of this before interpreting.

Conveying Cultural Frameworks
Interpreters shall explain cultural differences or practices to health care providers and clients when appropriate.

Non-Judgmental Attitude about the Content to be Interpreted
An interpreter's function is to facilitate communication. Interpreters are not responsible for what is said by anyone for whom they are interpreting. Even if the interpreter disagrees with what is said, thinks it is wrong, a lie or even immoral, the interpreter must suspend judgment, make no comment, and interpret everything accurately.

Client Self-Determination
The interpreter may be asked by the client for his or her opinion. When this happens, the interpreter may provide or restate information that will assist the client in making his or her own decision. The interpreter will not influence the opinion of patients or clients by telling them what action to take.

Attitude Toward Clients
The interpreter should strive to develop a relationship of trust and respect at all times with the client by adopting a caring, attentive, yet discreet and impartial attitude toward the patient, toward his or her questions, concerns and needs.

The interpreter shall treat each patient equally with dignity and respect regardless of race, color, gender, religion, nationality, political persuasion or life-style choice.

Acceptance of Assignments
If level of competency or personal sentiments makes it difficult to abide by any of the above conditions, the interpreter shall decline or withdraw from the assignment.

Interpreters should disclose any real or perceived conflict of interest that could affect their objectivity. For example, interpreters should refrain from providing services to family members or close personal friends except in emergencies. In personal relationships, it is difficult to remain unbiased or non-judgmental.

In emergency situations, interpreters may be asked to do interpretations for which they are not qualified.

The interpreter may consent only as long as all parties understand the limitations and no other interpreter is available.

Compensation
The fee agreed upon by the agency and the interpreter is the only compensation that the interpreter may accept. Interpreters will not accept additional money, considerations or favors for services reimbursed by the contracting agency. Interpreters will not use the agency's time, facilities, equipment or supplies for private gain, nor will they use their positions to secure privileges or exemptions.

Self-Evaluation
Interpreters shall represent their certification(s), training and experience accurately and completely.

Ethical Violations
Interpreters shall withdraw immediately from encounters that they perceive to be in violation of the Code of Ethics.

Professionalism
Interpreters shall be punctual, prepared and dressed in an appropriate manner. The trained interpreter is a professional who maintains professional behavior at all times while assisting clients and who seeks to further his or her knowledge and skills through continuing studies and training.

Source: This code is a combination of the Codes of Ethics from the Hospital Interpretation Program in Seattle, WA; Boston City Hospital in Boston, MA; and the American Medical Interpreters and Translators Association (AMITAS) in Stanford, CA.

CDC COMMUNICABLE DISEASES OF PUBLIC HEALTH SIGNIFICANCE

Refugee/Immigrants are inadmissible into the United States if they are determined 1) to have a communicable disease of public health significance; 2) to have a physical or mental disorder and behavior associated with the disorder that may pose, or has posed, a threat to the property, safety, or welfare of the applicant or others; 3) to have a history of a physical or mental disorder associated with behavior which posed a threat to the property, safety, or welfare of the applicant or others and which is likely to recur or lead to other harmful behavior; or 4) to be a drug abuser or addict.

Medical examinations, including a physical and mental evaluation, to determine whether an applicant may have such a health-related condition are authorized under section 232 of the INA (8 USC 1222). Under sections 212(a)(1) and 232 of the INA and section 325 of the Public Health Service (PHS) Act (42 USC 252), the HHS Secretary promulgates regulations to establish the requirements for the medical examination and to list the health-related conditions that make applicants ineligible for entry into the United States. Previous Part 34 regulations defined a “communicable disease of public health significance” by only listing eight specific diseases - active tuberculosis (TB), human immunodeficiency virus (HIV) infection (**no longer included**), chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, infectious syphilis, and infectious leprosy (Hansen’s disease).

Recent experience has demonstrated that a fixed list of diseases does not allow the flexibility to rapidly respond to unanticipated emerging or re-emerging outbreaks of disease. Therefore, HHS/CDC is adding the following disease categories to the current list of communicable diseases of public health significance:

1) Quarantinable, communicable diseases specified by Presidential Executive Order, as provided under Section 361(b) of the PHS Act;
2) Any communicable disease that requires notification to WHO of an event that may constitute a public health emergency of international concern, pursuant to the revised IHR of 2005.

The definition of communicable diseases of public health significance continues to include the diseases listed in the *Technical Instructions of Medical Examination of Aliens, June 1991*, and adds the following diseases:

Quarantinable, communicable diseases specified by any Presidential Executive Order under Section 361(b) of the PHS Act. Executive Order 13295 of April 4, 2003, as amended by Executive Order 13375 of April 1, 2005, contains the most recent list of quarantinable, communicable diseases, and includes the following:

- cholera
- yellow fever
- plague
- viral hemorrhagic fevers
- severe acute respiratory syndrome (SARS)
- diphtheria
- infectious TB
- smallpox
- influenza caused by novel or re-emergent influenza viruses that are causing, or have the potential to cause, a pandemic (e.g., avian H5N1 influenza virus)

Excerpted “Addendum to the Technical Instructions for Medical Examinations of Aliens-Updated Screening for Communicable Disease of Public Health Significance-Oct 6, 2008”

Specific Follow-up Recommendations for Tuberculosis
B1 and B2 TB Classifications

A TB Follow up Worksheet should be available to fill out and submit to the KDHE Tuberculosis (TB) Department for both B-1 and B-2 evaluations. If one is not available contact KDHE TB Dept. Phone #785-296-2547

Class B1 Status.

Refugees who are admitted to the United States with a diagnosis of Tuberculosis (TB) Disease are given a Class B-1. Below are the general guidelines to be followed when evaluating refugees with a B-1 classification:

- Review Medical exam records of the TB evaluation made before entering the United States. Identify the reason the patient was admitted to the U.S. with B1 status. Check to see if refugee has a chest X ray film or CD.
- Promptly evaluate refugee for symptoms of TB disease.
- If no TST or IGRA has been documented in the records, A TST or IGRA should be done.
- Collect three sputum samples per CDC guidelines.
- Repeat Chest x-ray. If overseas film or CD is available have a doctor compare the U.S. chest ray with the x-ray brought with the refugee/immigrant.
- After initial information, chest x-ray and lab results have been collected refer the refugee/immigrant to an appropriate medical provider in a timely manor. Based on the results of these tests the physician will diagnosis and decide the CDC recommended course of treatment.

Please note that no refugee arriving with a B-1 classification should be released before the above actions are completed and the TB Follow-up Worksheet is completed and faxed along with results to the KDHE TB Department.

Class B-2 Status

Refugees admitted with a B-2 class come into the country with a diagnosis of Latent Tuberculosis Infection (LTBI). TB disease needs to be ruled out by symptom review and repeat chest x-ray if done outside of the country. A TB Follow-up Worksheet also needs to be completed and faxed to the KDHE TB Dept.

For more information on CDC instructions and definitions for panel physicians to screen and classify applicants applying for immigration to the U.S. refer to CDC Immigration Requirements: Technical Instructions for Tuberculosis Screening and Treatment at http://www.kdheks.gov/olrh/resources_hc_practitioners.htm.

Recommended Immunization Schedule for Persons Aged 0 Through 6 Years—United States • 2009

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		*see footnote 1*	HepB						
Rotavirus[2]			RV	RV	*RV*[2]						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	*see footnote 3*	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPSV	
Inactivated Poliovirus			IPV	IPV	IPV						IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR	*see footnote 7*				MMR
Varicella[8]						Varicella	*see footnote 8*				Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 0 through 6 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). ***(Minimum age: birth)***

At birth:

- Administer monovalent HepB to all newborns before hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg)-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine mother's HBsAg status as soon as possible and, if HBsAg-positive, administer HBIG (no later than age 1 week).

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1 or 2 months. The final dose should be administered no earlier than age 24 weeks.
- Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg (anti-HBs) after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).

4-month dose:

- Administration of 4 doses of HepB to infants is permissible when combination vaccines containing HepB are administered after the birth dose.

2. Rotavirus vaccine (RV). ***(Minimum age: 6 weeks)***

- Administer the first dose at age 6 through 14 weeks (maximum age: 14 weeks 6 days). Vaccination should not be initiated for infants aged 15 weeks or older (i.e., 15 weeks 0 days or older).
- Administer the final dose in the series by age 8 months 0 days.
- If Rotarix® is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). ***(Minimum age: 6 weeks)***

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4 through 6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). ***(Minimum age: 6 weeks)***

- If PRP-OMP (PedvaxHIB® or Comvax® [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- TriHiBit® (DTaP/Hib) should not be used for doses at ages 2, 4, or 6 months but can be used as the final dose in children aged 12 months or older.

5. Pneumococcal vaccine. ***(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])***

- PCV is recommended for all children aged younger than 5 years. Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- Administer PPSV to children aged 2 years or older with certain underlying medical conditions (see *MMWR* 2000;49[No. RR-9]), including a cochlear implant.

6. Influenza vaccine. ***(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])***

- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if aged 6 through 35 months or 0.5 mL if aged 3 years or older.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

7. Measles, mumps, and rubella vaccine (MMR). ***(Minimum age: 12 months)***

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 28 days have elapsed since the first dose.

8. Varicella vaccine. ***(Minimum age: 12 months)***

- Administer the second dose at age 4 through 6 years. However, the second dose may be administered before age 4, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.

9. Hepatitis A vaccine (HepA). ***(Minimum age: 12 months)***

- Administer to all children aged 1 year (i.e., aged 12 through 23 months). Administer 2 doses at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA also is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

10. Meningococcal vaccine. ***(Minimum age: 2 years for meningococcal conjugate vaccine [MCV] and for meningococcal polysaccharide vaccine [MPSV])***

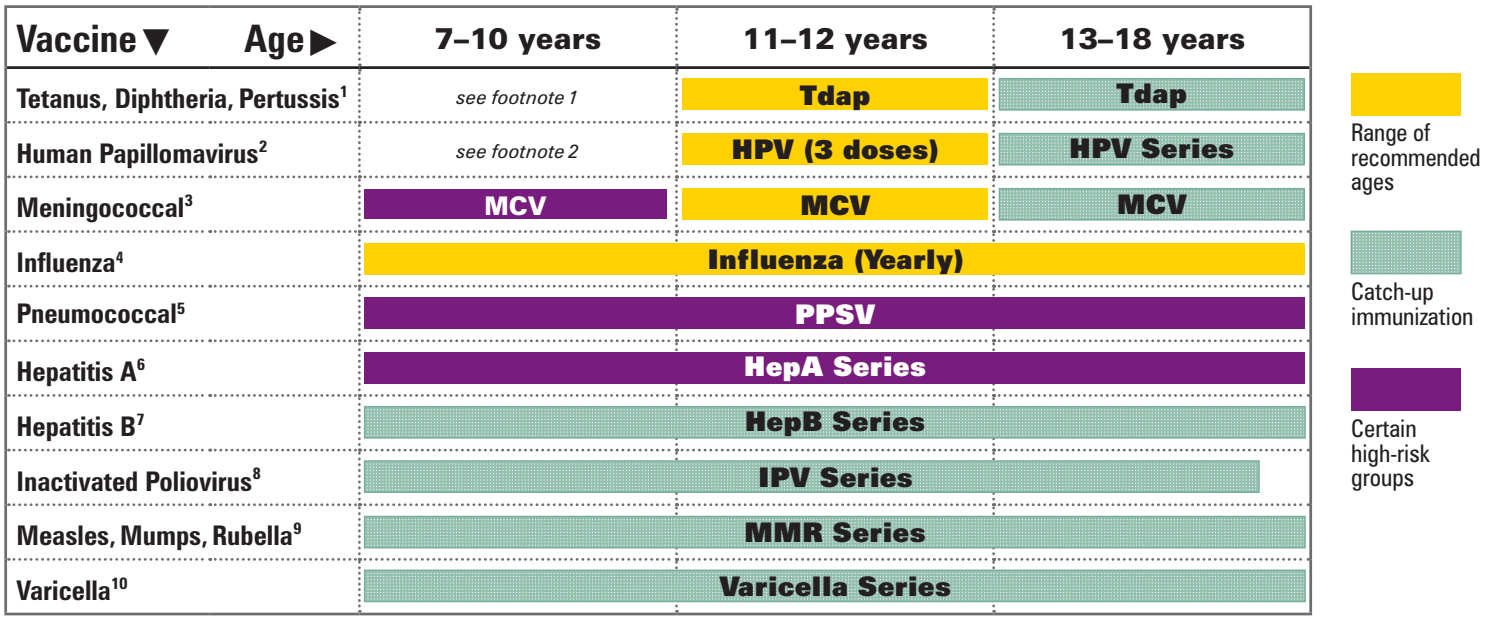
- Administer MCV to children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other high-risk groups. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 3 or more years previously and who remain at increased risk for meningococcal disease should be revaccinated with MCV.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Immunization Schedule for Persons Aged 7 Through 18 Years—United States • 2009

For those who fall behind or start late, see the schedule below and the catch-up schedule



This schedule indicates the recommended ages for routine administration of currently licensed vaccines, as of December 1, 2008, for children aged 7 through 18 years. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the relevant Advisory Committee on Immunization Practices statement for detailed recommendations, including high-risk conditions: http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). ***(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL®)***
- Administer at age 11 or 12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoid (Td) booster dose.
- Persons aged 13 through 18 years who have not received Tdap should receive a dose.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose; however, a shorter interval may be used if pertussis immunity is needed.

2. Human papillomavirus vaccine (HPV). ***(Minimum age: 9 years)***
- Administer the first dose to females at age 11 or 12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
- Administer the series to females at age 13 through 18 years if not previously vaccinated.

3. Meningococcal conjugate vaccine (MCV).
- Administer at age 11 or 12 years, or at age 13 through 18 years if not previously vaccinated.
- Administer to previously unvaccinated college freshmen living in a dormitory.
- MCV is recommended for children aged 2 through 10 years with terminal complement component deficiency, anatomic or functional asplenia, and certain other groups at high risk. See *MMWR* 2005;54(No. RR-7).
- Persons who received MPSV 5 or more years previously and remain at increased risk for meningococcal disease should be revaccinated with MCV.

4. Influenza vaccine.
- Administer annually to children aged 6 months through 18 years.
- For healthy nonpregnant persons (i.e., those who do not have underlying medical conditions that predispose them to influenza complications) aged 2 through 49 years, either LAIV or TIV may be used.
- Administer 2 doses (separated by at least 4 weeks) to children aged younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time during the previous influenza season but only received 1 dose.

5. Pneumococcal polysaccharide vaccine (PPSV).
- Administer to children with certain underlying medical conditions (see *MMWR* 1997;46[No. RR-8]), including a cochlear implant. A single revaccination should be administered to children with functional or anatomic asplenia or other immunocompromising condition after 5 years.

6. Hepatitis A vaccine (HepA).
- Administer 2 doses at least 6 months apart.
- HepA is recommended for children older than 1 year who live in areas where vaccination programs target older children or who are at increased risk of infection. See *MMWR* 2006;55(No. RR-7).

7. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those not previously vaccinated.
- A 2-dose series (separated by at least 4 months) of adult formulation Recombivax HB® is licensed for children aged 11 through 15 years.

8. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
- If not previously vaccinated, administer 2 doses or the second dose for those who have received only 1 dose, with at least 28 days between doses.

10. Varicella vaccine.
- For persons aged 7 through 18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4]), administer 2 doses if not previously vaccinated or the second dose if they have received only 1 dose.
- For persons aged 7 through 12 years, the minimum interval between doses is 3 months. However, if the second dose was administered at least 28 days after the first dose, it can be accepted as valid.
- For persons aged 13 years and older, the minimum interval between doses is 28 days.

The Recommended Immunization Schedules for Persons Aged 0 Through 18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

DEPARTMENT OF HEALTH AND HUMAN SERVICES • CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommended Adult Immunization Schedule

UNITED STATES - 2009

Note: These recommendations *must* be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

Figure 1. Recommended adult immunization schedule, by vaccine and age group

VACCINE ▼ / AGE GROUP ▶	19–26 years	27–49 years	50–59 years	60–64 years	≥65 years
Tetanus, diphtheria, pertussis (Td/Tdap)[1,*]	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs				Td booster every 10 yrs
Human papillomavirus (HPV)[2,*]	3 doses (females)				
Varicella[3,*]	2 doses				
Zoster[4]				1 dose	
Measles, mumps, rubella (MMR)[5,*]	1 or 2 doses		1 dose		
Influenza[6,*]	1 dose annually				
Pneumococcal (polysaccharide)[7,8]	1 or 2 doses				1 dose
Hepatitis A[9,*]	2 doses				
Hepatitis B[10,*]	3 doses				
Meningococcal[11,*]	1 or more doses				

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

Figure 2. Vaccines that might be indicated for adults based on medical and other indications

INDICATION ▶ / VACCINE ▼	Pregnancy	Immuno-compromising conditions (excluding human immunodeficiency virus [HIV])[13]	HIV infection[3,12,13] CD4+ T lympho-cyte count <200 cells/µL	HIV infection[3,12,13] CD4+ T lympho-cyte count ≥200 cells/µL	Diabetes, heart disease, chronic lung disease, chronic alcoholism	Asplenia[12] (including elective splenectomy and terminal complement component deficiencies)	Chronic liver disease	Kidney failure, end-stage renal disease, receipt of hemodialysis	Health-care personnel
Tetanus, diphtheria, pertussis (Td/Tdap)[1,*]	Td	Substitute 1-time dose of Tdap for Td booster; then boost with Td every 10 yrs							
Human papillomavirus (HPV)[2,*]		3 doses for females through age 26 yrs							
Varicella[3,*]	Contraindicated	2 doses							
Zoster[4]	Contraindicated	1 dose							
Measles, mumps, rubella (MMR)[5,*]	Contraindicated	1 or 2 doses							
Influenza[6,*]	1 dose TIV annually								1 dose TIV or LAIV annually
Pneumococcal (polysaccharide)[7,8]	1 or 2 doses								
Hepatitis A[9,*]	2 doses								
Hepatitis B[10,*]	3 doses								
Meningococcal[11,*]	1 or more doses								

*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2009. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm).

CS124645

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
CDC

Footnotes

Recommended Adult Immunization Schedule—UNITED STATES · 2009

For complete statements by the Advisory Committee on Immunization Practices (ACIP), visit www.cdc.gov/vaccines/pubs/ACIP-list.htm.

1. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination

Tdap should replace a single dose of Td for adults aged 19 through 64 years who have not received a dose of Tdap previously.

Adults with uncertain or incomplete history of primary vaccination series with tetanus and diphtheria toxoid-containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses of tetanus and diphtheria toxoid-containing vaccines; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. However, Tdap can substitute for any one of the doses of Td in the 3-dose primary series. The booster dose of tetanus and diphtheria toxoid-containing vaccine should be administered to adults who have completed a primary series and if the last vaccination was received 10 or more years previously. Tdap or Td vaccine may be used, as indicated.

If a woman is pregnant and received the last Td vaccination 10 or more years previously, administer Td during the second or third trimester. If the woman received the last Td vaccination less than 10 years previously, administer Tdap during the immediate postpartum period. A dose of Tdap is recommended for postpartum women, close contacts of infants aged less than 12 months, and all health-care personnel with direct patient contact if they have not previously received Tdap. An interval as short as 2 years from the last Td is suggested; shorter intervals can be used. Td may be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap may be administered instead of Td to a pregnant woman after an informed discussion with the woman.

Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management.

2. Human papillomavirus (HPV) vaccination

HPV vaccination is recommended for all females aged 11 through 26 years (and may begin at 9 years) who have not completed the vaccine series. History of genital warts, abnormal Papanicolaou test, or positive HPV DNA test is not evidence of prior infection with all vaccine HPV types; HPV vaccination is recommended for persons with such histories.

Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, females who are sexually active should still be vaccinated consistent with age-based recommendations. Sexually active females who have not been infected with any of the four HPV vaccine types receive the full benefit of the vaccination. Vaccination is less beneficial for females who have already been infected with one or more of the HPV vaccine types.

A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose.

HPV vaccination is not specifically recommended for females with the medical indications described in Figure 2, "Vaccines that might be indicated for adults based on medical and other indications." Because HPV vaccine is not a live-virus vaccine, it may be administered to persons with the medical indications described in Figure 2. However, the immune response and vaccine efficacy might be less for persons with the medical indications described in Figure 2 than in persons who do not have the medical indications described or who are immunocompetent. Health-care personnel are not at increased risk because of occupational exposure, and should be vaccinated consistent with age-based recommendations.

3. Varicella vaccination

All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only one dose unless they have a medical contraindication. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care personnel and family contacts of persons with immunocompromising conditions) or 2) are at high risk for exposure or transmission (e.g., teachers; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers).

Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care personnel and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or to a laboratory-confirmed case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on health-care provider diagnosis or verification of herpes zoster by a health-care provider; or 5) laboratory evidence of immunity or laboratory confirmation of disease.

Pregnant women should be assessed for evidence of varicella immunity. Women who do not have evidence of immunity should receive the first dose of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. The second dose should be administered 4–8 weeks after the first dose.

4. Herpes zoster vaccination

A single dose of zoster vaccine is recommended for adults aged 60 years and older regardless of whether they report a prior episode of herpes zoster. Persons with chronic medical conditions may be vaccinated unless their condition constitutes a contraindication.

5. Measles, mumps, rubella (MMR) vaccination

Measles component: Adults born before 1957 generally are considered immune to measles. Adults born during or after 1957 should receive 1 or more doses of MMR unless they have a medical contraindication, documentation of 1 or more doses, history of measles based on health-care provider diagnosis, or laboratory evidence of immunity.

A second dose of MMR is recommended for adults who 1) have been recently exposed to measles or are in an outbreak setting; 2) have been vaccinated previously with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health-care facility; or 6) plan to travel internationally.

Mumps component: Adults born before 1957 generally are considered immune to mumps. Adults born during or after 1957 should receive 1 dose of MMR unless they have a medical contraindication, history of mumps based on health-care provider diagnosis, or laboratory evidence of immunity.

A second dose of MMR is recommended for adults who 1) live in a community experiencing a mumps outbreak and are in an affected age group; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. For unvaccinated health-care personnel born before 1957 who do not have other evidence of mumps immunity, administering 1 dose on a routine basis should be considered and administering a second dose during an outbreak should be strongly considered.

Rubella component: 1 dose of MMR vaccine is recommended for women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, rubella immunity should be determined and women should be counseled regarding congenital rubella syndrome. Women who do not have evidence of immunity should receive MMR upon completion or termination of pregnancy and before discharge from the health-care facility.

6. Influenza vaccination

Medical indications: Chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal or hepatic dysfunction, hemoglobinopathies, or immunocompromising conditions (including immunocompromising conditions caused by medications or human immunodeficiency virus [HIV]); any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia.

Occupational indications: All health-care personnel, including those employed by long-term care and assisted-living facilities, and caregivers of children less than 5 years old.

Other indications: Residents of nursing homes and other long-term care and assisted-living facilities; persons likely to transmit influenza to persons at high risk (e.g., in-home household contacts and caregivers of children aged less than 5 years old, persons 65 years old and older and persons of all ages with high-risk condition[s]); and anyone who would like to decrease their risk of getting influenza. Healthy, nonpregnant adults aged less than 50 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered live, attenuated influenza vaccine (FluMist®) or inactivated vaccine. Other persons should receive the inactivated vaccine.

7. Pneumococcal polysaccharide (PPSV) vaccination

Medical indications: Chronic lung disease (including asthma); chronic cardiovascular diseases; diabetes mellitus; chronic liver diseases, cirrhosis; chronic alcoholism, chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunocompromising conditions; and cochlear implants and cerebrospinal fluid leaks. Vaccinate as close to HIV diagnosis as possible.

Other indications: Residents of nursing homes or long-term care facilities and persons who smoke cigarettes. Routine use of PPSV is not recommended for Alaska Native or American Indian persons younger than 65 years unless they have underlying medical conditions that are PPSV indications. However public health authorities may consider recommending PPSV for Alaska Natives and American Indians aged 50 through 64 years who are living in areas in which the risk of invasive pneumococcal disease is increased.

8. Revaccination with PPSV

One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); and for persons with immunocompromising conditions. For persons aged 65 years and older, one-time revaccination if they were vaccinated 5 or more years previously and were aged less than 65 years at the time of primary vaccination.

9. Hepatitis A vaccination

Medical indications: Persons with chronic liver disease and persons who receive clotting factor concentrates.

Behavioral indications: Men who have sex with men and persons who use illegal drugs.

Occupational indications: Persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting.

Other indications: Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at wwwn.cdc.gov/travel/contentdiseases.aspx) and any person seeking protection from HAV infection.

Single-antigen vaccine formulations should be administered in a 2-dose schedule at either 0 and 6–12 months (Havrix®), or 0 and 6–18 months (Vaqta®). If the combined hepatitis A and hepatitis B vaccine (Twinrix®) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7 and 21 to 30 followed by a booster dose at month 12 may be used.

10. Hepatitis B vaccination

Medical indications: Persons with end-stage renal disease, including patients receiving hemodialysis; persons with HIV infection; and persons with chronic liver disease.

Occupational indications: Health-care personnel and public-safety workers who are exposed to blood or other potentially infectious body fluids.

Behavioral indications: Sexually active persons who are not in a long-term, mutually monogamous relationship (e.g., persons with more than 1 sex partner during the previous 6 months); persons seeking evaluation or treatment for a sexually transmitted disease; current or recent injection-drug users; and men who have sex with men.

Other indications: Household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for persons with developmental disabilities; international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at wwwn.cdc.gov/travel/contentdiseases.aspx); and any adult seeking protection from HBV infection.

Hepatitis B vaccination is recommended for all adults in the following settings: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings targeting services to injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities.

If the combined hepatitis A and hepatitis B vaccine (Twinrix®) is used, administer 3 doses at 0, 1, and 6 months; alternatively, a 4-dose schedule, administered on days 0, 7 and 21 to 30 followed by a booster dose at month 12 may be used.

Special formulation indications: For adult patients receiving hemodialysis or with other immunocompromising conditions, 1 dose of 40 µg/mL (Recombivax HB®) administered on a 3-dose schedule or 2 doses of 20 µg/mL (Engerix-B®) administered simultaneously on a 4-dose schedule at 0, 1, 2 and 6 months.

11. Meningococcal vaccination

Medical indications: Adults with anatomic or functional asplenia, or terminal complement component deficiencies.

Other indications: First-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [December–June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj.

Meningococcal conjugate (MCV) vaccine is preferred for adults with any of the preceding indications who are aged 55 years or younger, although meningococcal polysaccharide vaccine (MPSV) is an acceptable alternative. Revaccination with MCV after 5 years might be indicated for adults previously vaccinated with MPSV who remain at increased risk for infection (e.g., persons residing in areas in which disease is epidemic).

12. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used

Hib vaccine generally is not recommended for persons aged 5 years and older. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults. However, studies suggest good immunogenicity in persons who have sickle cell disease, leukemia, or HIV infection or who have had a splenectomy; administering 1 dose of vaccine to these persons is not contraindicated.

13. Immunocompromising conditions

Inactivated vaccines generally are acceptable (e.g., pneumococcal, meningococcal, and influenza [trivalent inactivated influenza vaccine]), and live vaccines generally are avoided in persons with immune deficiencies or immunocompromising conditions. Information on specific conditions is available at www.cdc.gov/vaccines/pubs/acip-list.htm.

Requirements for routine vaccination of adjustment of status applicants who are not fully vaccinated or lack documentation.

Vaccine	Age						
	Birth–1 month	2–11 months	12 months–6 years	7–10 years	11–17 years	18–64 years	≥65 years
DTP/DTaP/DT	NO	YES		NO			
Td/Tdap	NO			YES, ≥7 years old (for Td); 10–64 years old (for Tdap)			
IPV	NO	YES				NO	
MMR	NO		YES, if born in 1957 or later				NO
Rotavirus	NO	YES 6 weeks to 8 months	NO				
Hib	NO	YES 2–59 months old		NO			
Hepatitis A	NO		YES 12–23 months old	NO			
Hepatitis B	YES, through 18 years old						NO
Meningococcal (MCV4)	NO				Yes 11–18 years old		NO
Varicella	NO		YES				
Pneumococcal	NO	YES, 2–59 months old (for PCV)		NO			YES (for PPV)
Influenza	NO	YES, 6 months through 18 years old (annually each flu season)				NO	YES, ≥50 years old (annually each flu season)

DTP=diphtheria and tetanus toxoids and pertussis vaccine; DTaP=diphtheria and tetanus toxoids and acellular pertussis vaccine; DT=pediatric formulation diphtheria and tetanus toxoids; Td=adult formulation tetanus and diphtheria toxoids; Tdap=adolescent and adult formulation tetanus and diphtheria toxoids and acellular pertussis vaccine (Boostrix for persons 10–18 years old; Adacel for persons 11–64 years old); IPV=inactivated poliovirus vaccine (killed); MMR=combined measles, mumps, and rubella vaccine; Hib=*Haemophilus influenzae* type b conjugate vaccine; MCV=meningococcal conjugate vaccine; PCV=pneumococcal conjugate vaccine; PPV=pneumococcal polysaccharide vaccine.

Adapted from ACIP recommendations.

KANSAS

Mark Parkinson, Governor
Roderick L. Bremby, Secretary

DEPARTMENT OF HEALTH
AND ENVIRONMENT

www.kdheks.gov

Division of Health

M E M O R A N D U M

DATE: December 11, 2009

TO: Local Health Department Administrators

FROM: Sue Bowden, RN BS, Director, Kansas Immunization Program

Charles Hunt, State Epidemiologist

SUBJECT: Provision of Immunizations to refugees

All health departments providing refugee health assessments are requested to offer and administer immunizations to those refugees who are not vaccinated or have no documentation of vaccination.

- Children 0-18 years of age may be vaccinated according to the most recent ACIP recommended schedule using VFC vaccine.
- Adults 19 years and older may received 1 Td and 1 MMR (required by INS) using State General Fund (SGF) provided vaccine. Document the doses on the Monthly Immunization Report (MIR) under doses administered. In addition, note the number of doses in the special box indicated on the bottom of the MIR.
- Adults may receive 1 dose of Varicella (2 doses if needed) using private stock vaccine. These doses are to be billed to the Refugee Health Program, if administered before the end of the eighth month from the day of entrance into the United States. The Refugee Health Program will not provide reimbursement for doses of Varicella administered *after* the eighth month from the day of entrance into the United States. Health Departments may not use Varicella supplied to them by the Kansas Immunization Program to vaccinate adults 19 years and older.
- Any other vaccinations administered to adults 19 years and older, including Pneumococcal and Influenza vaccine (in season), will require the use of private stock vaccine by the health department.

Kansas Immunization Program
Bureau of Epidemiology and Disease Prevention
DIVISION OF HEALTH
Curtis State Office Building, 1000 SW Jackson, Suite 210, TOPEKA, KS 66612-1274
Voice 785-296-5591 Fax 785-296-6510 Web Site http://www.kdheks.gov/immunize
For Disease Reporting and Public Health Emergencies: Toll-Free Phone 1-877-427-7317 Toll-Free Fax 1-877-427-7318

ORR's Domestic Medical Screening Guidelines Checklist*

Activity	All	Adults	Children
History & Physical Exam			
History (includes review of overseas medical records)	✓		
Physical Exam & Review of Systems (includes mental health, dental, hearing, and vision screening; nutritional, reproductive assessment; health education and anticipatory guidance, etc.)	✓		
Laboratory Tests			
Complete Blood Count with Differential	✓		
Serum Chemistries	✓		
Urinalysis	✓		
Cholesterol		✓ In accordance with the US Preventive Services Task Force guidelines	
Pregnancy Testing		✓ Women of childbearing age; using opt-out approach	✓ Girls of childbearing age; using opt-out approach or with consent from guardian
HIV Testing	✓ Opt-out approach		
Hepatitis B Testing	✓		
Hepatitis C Testing		✓ Individuals with risk factors (e.g., persons who have body art, received blood transfusions, etc.)	✓ Children with risk factors (e.g., hepatitis C -positive mothers, etc.)
Blood Lead Level			✓ Children 6 months to 16 years
Syphilis Testing		✓	✓ Children 15 years or older; children under 15 years old with risk factors
Syphilis Confirmation Test		✓ Individuals with positive VDRL or RPR tests	✓ Children with positive VDRL or RPR tests
Chlamydia Testing		✓ Women ≤ 25 years who are sexually active or those with risk factors	✓ Girls 15 years or older who are sexually active or children with risk factors

*For specifics, see CDC guidelines at: http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html. These *screening* guidelines are for *asymptomatic* refugees. Refugees with signs or symptoms should receive diagnostic testing.

ORR's Domestic Medical Screening Guidelines Checklist*

Activity	All	Adults	Children
Newborn Screening Tests [1]			✓ Within first year of life
Preventive Health Interventions & Other Screening Activities			
Immunizations [2]		✓ Individuals with incomplete or missing immunization records	✓ Children with incomplete or missing immunization records
Tuberculosis Screening [3]	✓		
Stool Ova and Parasite Testing [4]		✓ Individuals who had contraindications to albendazole at pre-departure (e.g., women in the first trimester of pregnancy)	✓ Children who had contraindications to albendazole at pre-departure (e.g., under 1year)
Strongyloidiasis Presumptive Treatment [2, 5]		✓ Individuals who did not receive pre-departure presumptive treatment. Currently, only Burmese refugees originating from Thailand are treated prior to arrival. Therefore, all groups of refugees PLUS Burmese originating from Thailand who had contraindications at departure (e.g., pregnant) should be presumptively treated after arrival	✓ Children who did not receive pre-departure presumptive treatment. Currently, only Burmese refugees originating from Thailand are treated prior to arrival. Therefore, all groups of refugees PLUS Burmese originating from Thailand who had a contraindication (e.g., <15 kg) at departure should be presumptively treated after arrival
Schistosomiasis Presumptive Treatment [2, 6]		✓ Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pre-existing seizures) that are not resolvable should be tested rather than treated	✓ Children from sub-Saharan Africa who had contra-indications to presumptive treatment at pre-departure (e.g., under 4 years)
Malaria Testing [4, 6]		✓ Individuals from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pregnant, lactating)	✓ Children from sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., < 5 kg)
Vitamins		✓ Individuals with clinical evidence of poor nutrition	✓ All children 6-59 months of age; children 5 years and older with clinical evidence of poor nutrition

[1] *According to state standards; see: http://genes-r-us.uthscsa.edu/resources/consumer/statemap.htm*

[2] *Serological testing is an acceptable alternative*

[3] *Tuberculosis screening may include IGRA or TST/PPD testing and/or chest x-ray*

[4] *Presumptive treatment is an acceptable alternative to testing, provided the contraindication has resolved*

[5] *Ivermectin is the drug of choice, but is contraindicated in refugees from Loa loa endemic areas of Africa. In African refugees from Loa loa endemic areas, presumptive treatment is more expensive and complicated (e.g. high dose albendazole) and it may be more feasible to conduct serologic testing with treatment of those found to have infection*

[6] *Presumptive treatment is only recommended in refugees from sub-Saharan Africa. Currently, all sub-Saharan refugees without contraindications are receiving pre-departure treatment.*

*For specifics, see CDC guidelines at: http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html. These *screening* guidelines are for *asymptomatic* refugees. Refugees with signs or symptoms should receive diagnostic testing.

COUNTRY CODE TABLE

AC Antigua
AF Afghanistan
AG Algeria
AJ Azerbaijan
AL Albania
AM Armenia
AN Andorra
AO Angola
AQ American Samoa
AR Argentina
AS Australi a
AU Austria
AV Anguilla
AY Antarctic a
BA Bahrain
BB Barbados
BC Bots wana
BD Bermuda
BE Belgium
BF Bahamas, The
BG Bangladesh
BH Belize
BK Bosnia and Herzegovina
BL Bolivia
BM Burma
BO Belarus
BP Solom on Islands
BQ Navassa Island
BR Brazil
BT Bhutan
BU Bulgaria
BV Bouvet Island
BX Brunei
BY Burundi
CA Canada
CB Kampuchea
CD Chad
CE Sri Lanka
CF Congo, Peoples Republic of the
CG *Congo, Democratic Republic of the*
CH China, Peoples Republic of
CI Chile
CJ Cayman Islands
CK Cocos (Keeling) Islands
CM Cameroon
CN Comoros
CO Colombia
CQ Northern Mariana Islands
CR Coral Sea Islands Territory
CS Costa Rica
CT Central African Republic
CU Cuba
CV Cape Verde
CW Cook Islands
CY Cyprus
CZ Czechosl ovakia
DA Denmark
DJ Djibouti, Republic of
DM Benin
DO Dominica
DR Dominican Republic
EC Ecuad or
EG Egypt
EI Ireland
EK Equat orial Guinea
EN Est onia
EQ Canton And Enderbury Islands
ER Eritrea
ES El Salvador
ET Ethiopi a
EZ Czech Republic
FA Falkland Islands (Islas Malvinas)
FG French Guiana
FI Finland
FJ Fiji
FO Faroe Islands
FP French Polynesia
FR France
FS French Southern And Antarctic Lands
GA Gambia, The
GB Gabon
GG Georgia
GH Ghana
GI Gibraltar
GJ Grenada
GL Greenland
GM Germany
GP Guadeloupe
GQ Guam
GR Greece
GS Gilbert Islands
GT Guatemal a
GV Guinea
GY Guyana
GZ Gaza Strip
HA Haiti
HK Hong Kong *(China)*
HM Heard Island And Mcdonald Islands
HO Hondura s
HR Croati a
HU Hungary

IC Iceland
ID Indonesi a
IN India
IO British Indian Ocean Territory
IQ United States Misc. Pacific Islands
IR Iran
IS Israel
IT Italy
IV Ivory Coast
IY Iraq-Saudi Arabia Neutral Zone
IZ Iraq
JA Jap an
JM Jam aica
JO Jorda n
JQ John ston Atoll
JS Svalbard and Jan Mayen
KE Kenya
KG Kyrgyzstan
KN Korea, Democratic People's Republic of
KR Kiribati
KS Korea, Republic of
KT Christmas Island (Indian Ocean)
KU Kuwait
KZ Kazakh stan
LA Laos
LE Lebanon
LG Latvia
LH Lithuania
LI Liberia
LO Slovak Republic
LS Liechten stein
LT Lesotho
LU Luxembourg
LY Libya
MA Mad agascar
MB Martinique
MC Mac au
MD Moldov a
MG Mong olia
MH Mont serrat
MI Mal awi
MK Former Yugoslav Republic of Macedonia
ML Mali
MN Mon aco
MO Mor occo
MP Mauritiu s
MQ Midway Islands
MR Maurit ania
MT Malt a
MU Oman
MV Maldives
MX Mexic o
MY Mal aysia
MZ Moz ambique
NA Netherland s Antilles
NC New Caledonia
NE Niue
NF Norfolk Island
NG Niger
NH New Hebrides
NI Nigeria
NL Netherlands
NO Norway
NP Nepal
NR Nauru
NS Suriname
NU Nicaragua
NZ New Zealand
PA Paragu ay
PC Pitcairn Islands
PE Peru
PF Paracel Islands
PG Spratly Islands
PK Pakistan
PL Poland
PM Panam a
PO Portugal
PP Papua New Guinea
PQ Canal Zone
PS Trust Territory of Pacific Islands
PU Guinea-Bis sau
QA Qatar
RE Reunion
RO Rom ania
RP Philippines
RQ Puerto Rico
RS Rus sia
RW Rwand a
SA Saudi Arabia
SB St. Pierre and Miquelon
SC St. Kitts and Nevis
SE Seychelles
SF South Africa
SG Senegal
SH St. Helena
SI Slovenia
SL Sierra Leone
SM San Marino
SN Singapore
SO Somali a
SP Spain
ST St. Lucia
SU Sudan
SW Sweden
SY Syria
SZ Switzerland

TC United Arab Emirates
TD Trinidad and Tobago
TH Thail and
TI Tajiki stan
TK Turks and Caicos Islands
TL Tokel au
TN Tong a
TO Tog o
TP Sao Tome and Principe
TS Tunisi a
TU Turkey
TV Tav alu
TW China (Taiwan)
TX Turkmeni stan
TZ Tanzania, United Republic of
UG Ugand a
UK United Kingdom
UP Ukraine
US United States
UV Burkina Faso
UY Uruguay
UZ Uzbekis tan
VC St. Vincent and the Grenadines
VE Venezuel a
VI British Virgin Islands
VM Vietn am
VQ US Virgin Islands
VT The Holy See
WA N amibia
WF Wallis and Futuna
WI We stern Sahara
WQ Wake Island
WS We stern Samoa
WZ Swaziland
YM Yemen
YO Yugoslavi a
ZA Zambia
ZI Zimbabwe