

**Newcomer Health Program
Supplemental Data Collection Form**

Country of Origin: _____
Country of Exit: _____

Place Patient **ENCOUNTER** Label Here:
Name: _____
DOB: _____ Pt #: _____
Encounter #: _____

Alien ID#: _____
Date of Arrival in US: _____
VOLAG: _____
Health District: _____

Did the patient receive an initial health screening? Yes No **DATE OF INITIAL ASSESSMENT:** ____/____/____
If the patient did not receive a screening, why not? Moved Refused Never located Missed multiple appts.
 Unknown Other _____

Please provide an appropriate response to each question.

Assessment Findings: Is the patient: Male Female

Was the dental evaluation WNL? Yes No N/A Referral needed? Yes No
Was the hearing evaluation WNL? Yes No N/A Referral needed? Yes No
Was the vision evaluation WNL? Yes No N/A Referral needed? Yes No
Were nutritional abnormalities found? Yes No Referral needed? Yes No
For children, was the developmental assessment WNL? Yes No Referral needed? Yes No N/A
If female, was the pregnancy test: Not Done Pos Neg. Referral needed? Yes No
Was the mental health screening WNL? Not Done Yes No Referral needed? Yes No

Was the patient referred for follow up on any of the following? (Check all that apply.)
 Diabetes HTN Mental Health Suicidal Thoughts Neurology
 GI Issues Orthopedics OBGYN Infectious Disease HIV
 Elevated Cholesterol Disability Services Other (specify) _____

Was the client referred/linked to a Primary Care Provider? Yes No

Laboratory Findings:

Was the CBC WNL? Not Done Yes No Referral needed? Yes No
Was the metabolic panel WNL? Not Done Yes No Referral needed? Yes No
Were the HepB Surface Antigen Results WNL? Not Done Yes No Referral needed? Yes No
Was the HIV result WNL? Not Done Yes No Referral needed? Yes No
Was the RPR result WNL? Not Done Yes No Referral needed? Yes No
Was the Urinalysis WNL? Not Done Yes No Referral needed? Yes No
Were the Hepatitis C results WNL? Not Done Yes No Referral needed? Yes No

Tuberculosis Screening: Comments: _____

Test for TB infection (TST or IGRA) Pos Neg. Not Done _____
If the patient was referred for a chest x-ray was it WNL? Yes No Not Done _____
Was treatment recommended for: **Active TB Disease?** Yes No **LTBI?** Yes No _____

Person Completing Form: _____ **Phone #:** (____) _____
Print Name (Last Name, First Name)