

VIRGINIA DEPARTMENT OF HEALTH

# Screening Instructions and Forms

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Newcomer Health Program

## General Instructions

This packet contains the following **compulsory forms**:

- Newcomer Health Encounter form and instructions
- Newcomer Health Initial Health Screening Report form (to be faxed)
- Follow-up Vaccine form (to be faxed)

The following forms can be replaced based on staff convenience, as long as the replacements collect the same data:

- Newcomer Health Screening Results form and instructions
- Newcomer Health Individual Health History form and instructions
- Newcomer Health Initial Health Screening Abnormalities form and instructions
- Newcomer Health Healthcare Provider Signature Sheet form

Questions, feedback and comments should be directed to:

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*Jill Grumbine, BSN, RN*

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Newcomer Health Program Coordinator

Virginia Department of Health

Division of Disease Prevention

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## Newcomer Health Encounter Form

Place encounter label here: _____ Date: _____  Name: _____  DOB: _____ Pt #: _____  Encounter # _____	Subprogram: RF                      Diagnosis Code: Z02.89 Setting: _____                      ORG ID: 135807260  Provider # _____                      Provider Time: _____ Provider # _____                      Provider Time: _____
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### HISTORY AND PHYSICAL EXAM/ASSESSMENT

- ☐ Performed by MD  
☐ Performed by NP\*  
☐ Performed by PHN†  
 99381 ☐ H&PA <1 year  
 99382 ☐ H&PA 1-4 years  
 99383 ☐ H&PA 5-11 years  
 99384 ☐ H&PA 12-17 years  
 99385 ☐ H&PA 18-39 years  
 99386 ☐ H&PA 40-64 years  
 99387 ☐ H&PA ≥65 years

\*For exams performed by NP use NP exception code

†For exams performed by PHN use PHN exception code

### LABORATORY TESTS FOR ALL PATIENTS

#### CBC

L5009 ☐ CBC w/Plate and Diff

#### Serum Chemistries

L322758 ☐ Basic metabolic panel

#### Urinalysis

For all able to provide clean catch specimen; only select one of the below.

- 81000 ☐ Urine Dip, (non-automated, with microscopy)  
 81001 ☐ Urine Dip, (automated, with microscopy)  
 81002 ☐ Urine Dip, (non-automated, without microscopy)  
 81003 ☐ Urine Dip, (automated, without microscopy)

#### HIV Testing

For all persons 13-64 years of age; testing for those ≤12 and ≥64 encouraged

L83935 ☐ HIV 1/O/2

#### Hepatitis B Testing

Choose Hepatitis B Panel for adults; choose Hepatitis B Surface Antigen only for children <18 years, if from low to intermediate endemic areas. Testing performed overseas does not need to be repeated.

- L219949 ☐ Hepatitis B Panel  
 L6510 ☐ Hepatitis B surface antigen

Updated: 5/7/2019

### Lab Charges

- 36415 ☐ Venipuncture  
 36416 ☐ Capillary Blood Sample  
 99000 ☐ Lab Handling Fee

### TB TESTING

- L182879 ☐ QuantiFERON TB Gold 4 tube IGRA  
 86480A ☐ QuantiFERON Gold Test (NOVA price code)  
 TspotTB ☐ T-Spot IGRA  
 86580 ☐ TST Admin  
 PPREAD ☐ mm ☐ POS ☐ NEG

(Districts may leave Z11.1 default diagnosis code)

- 71045 ☐ Chest x-ray, frontal  
 71046 ☐ Chest x-ray, PA and lateral
- } Use RF exception code

- TBSPEC1 ☐ TB Culture AFB & Smear  
 TBSPEC2 ☐ TB Culture AFB & Smear  
 TBSPEC3 ☐ TB Culture AFB & Smear
- } Send to DCLS

### LABORATORY TESTS FOR SPECIFIC PATIENTS

#### Cholesterol

Screen men ≥35 years and women ≥45 years; can be checked non-fasting. Screen beginning at age 20 individuals at increased risk for CAD (diabetes, tobacco use, HTN, familial history of cardiovascular disease)

L303756 ☐ Lipid Profile

#### Pregnancy Testing

For females of childbearing age

81025 ☐ UPT (use secondary diagnosis code depending on result)

☐ Pos (Z32.01)                      ☐ Neg (Z32.02)

#### Blood Lead Level/Iron studies

Choose 717009 for children 6 months – 16 years; and one or more of the nutritional tests if < 6 years **if needed**

- L717009 ☐ Assay of lead  
 L1339 ☐ Serum Iron  
 L5280 ☐ Reticulocyte/Hgb count

#### Hepatitis C Testing

All refugees born from 1945-1965 and those with risk factors – injection drug use, body art, blood transfusion recipient, HIV, known exposure, etc.

L144045 ☐ Hepatitis C antibody

## Syphilis Screen

If no documentation, Test all refugees >15 years of age and ≤15 with risk factors

L82345 \_\_\_\_ T Pallidum Screening Cascade

## Chlamydia Testing

Women ≤25 who are sexually active or those with risk factors; women >25 years with risk factors; Leucoesterase + on urine sample; any refugee with symptoms

L183194 \_\_\_\_ Chlamydia/ gonorrhea (urine)

**Serology** – use for 19 years and older if no documentation of vaccine receipt

L96206 \_\_\_\_ Varicella IgG

L58495 \_\_\_\_ Measles, Mumps, Rubella immunity

**Newborn Screening** (within first 6 months of life) } Send to DCLS  
NBSCR \_\_\_\_ Newborn Screening Outpatient

## IMMUNIZATIONS

Use chargeable vaccines for adults and select FF price code

90700 \_\_\_\_ DTaP

90632 \_\_\_\_ Hepatitis A adult

90633 \_\_\_\_ Hepatitis A pediatric

90746 \_\_\_\_ Hepatitis B adult Free/Charge/Study

90744 \_\_\_\_ Hepatitis B pediatric

90636 \_\_\_\_ HepA/Hep B (Twinrix) Free/Charge/Study

90648 \_\_\_\_ Hib

Varies \_\_\_\_ Influenza<sup>£</sup> Free/Charge

90651 \_\_\_\_ HPV9

90713 \_\_\_\_ IPV

90696 \_\_\_\_ Kinrix (DTaP/IPV)

90734 \_\_\_\_ MCV4

90707 \_\_\_\_ MMR<sup>£</sup> Free/Charge

90710 \_\_\_\_ MMRV

90670 \_\_\_\_ PCV13<sup>£</sup>

90723 \_\_\_\_ Pediarix (DTaP/IPV/Hep-B)

90698 \_\_\_\_ Pentacel (DTaP/IPV/Hib)

90732 \_\_\_\_ PPV23<sup>£</sup>

90681 \_\_\_\_ Rotarix

90680 \_\_\_\_ Rotateq

90714 \_\_\_\_ Td<sup>£</sup> Free/Charge

90715 \_\_\_\_ Tdap<sup>£</sup> Free/Charge

90716 \_\_\_\_ Varicella<sup>£</sup> Free/Charge

90471 \_\_\_\_ First Injectable Vaccine Admin. Fee

90472 \_\_\_\_ Each Add'l Injectable Vaccine Admin. Fee

90473 \_\_\_\_ First Oral/Nasal Vaccine Admin. Fee

90474 \_\_\_\_ Each Add'l Oral/Nasal Vaccine Admin. Fee

## OTHER

99213 \_\_\_\_ Clinician Visit 2

(use if pt is seen for a f/u visit)

99211 \_\_\_\_ Nurse Visit

RFGINTP \_\_\_\_ Refugee Interpretation Services

(1 time charge only)

RFGMHSC \_\_\_\_ Refugee Mental Health Screening

\_\_\_\_ Update Address and Phone number

## OVA and PARASITE

\*\*\*Pt's in need of presumptive treatment should be given a RX to have filled at a pharmacy. **Clinicians should write the following on the RX: "CDC directed therapy for refugees"**

L8623 \_\_\_\_ O&P Stool Testing

**MEDICATIONS – to be used only with preapproval from the NHP. \*\*\* (Reserved for those who don't qualify for Medicaid.)**

RD603A \_\_\_\_ Malarone Adult (Atovaquone 250mg; Proguanil 100mg) \_\_\_\_ #of pills

RD604A \_\_\_\_ Malarone Child (Atovaquone 62.5mg; Proguanil 25mg) \_\_\_\_ #of pills

Refugees who did not receive pre-departure treatment for malaria should be treated **within 3 months** of arrival

RD611B \_\_\_\_ Praziquantel (Biltricide) 600mg \_\_\_\_ # tabs

RD765 \_\_\_\_ Praziquantel (Biltricide) 600mg 6tabs

RD763A \_\_\_\_ Albenza \_\_\_\_ #of pills

RD764 \_\_\_\_ Stromectol bottle of 20

RD764A \_\_\_\_ Stromectol \_\_\_\_ #of pills

\*\*\*For medication preapproval, please call Jill Grumbine at 804-864-7911.

## FOLIC ACID

FAC \_\_\_\_ Folic Acid Counseling

R886 \_\_\_\_ Folic Acid – 400 MCG 100's

MVC \_\_\_\_ Multivitamin w/Folic Acid Counsel

R593 \_\_\_\_ Vitamins w/.8mg Folic Acid

Updated: 5/7/2019

**£ = Newcomer Health will cover charges for these vaccines provided to adults.**

**Vaccines for children should be billed to Medicaid.**

# Instructions for filling out the Newcomer Health Encounter Form

## History and Physical Exam/Assessment

Select the level of health professional performing the H&P. If more than 1 level of health professional is participating in the initial health screening, choose the **highest** level of practitioner participating in the exam/assessment. If, for example, the history is done by the PHN and the physical is done by the NP or MD, choose the MD or NP reimbursement code.

- History – Includes review of overseas medical records; careful questioning on symptoms such as fever, weight loss, abdominal complaints, skin issues, review of systems for symptoms and complaints, known medical conditions, etc.
- Physical – includes, at minimum, assessment of nutritional status, height, weight, head circumference for children <2, pulse, respiratory rate, blood pressure, hearing and vision, oral exam, skin assessment, listening to heart and lung sounds, palpation for liver and spleen enlargement (defer for assessment by PHN), full lymph node exam (PHNs may defer full lymph node exam, but should assess gross cervical and axillary abnormalities). Genital exam may be deferred.
- Developmental status should be assessed for children ages 9-30 months according to the CDC and the American Academy of Pediatrics guidelines.

## Laboratory Tests for All Clients

The following laboratory testing should be performed for all refugees receiving a health screening:

- CBC
- Basic Metabolic Profile
- Urinalysis – if old enough to provide a clean-catch urine specimen. For adults also receiving urine testing for Chlamydia/GC collect the urine for this test first, and then collect the clean catch for urinalysis.
  - Districts may choose which type of urine dip to perform based on local resources.
- HIV – for all refugees unless they decline. If a refugee declines HIV testing, be sure to document this in the chart.
  - Children less than 13 years of age should be screened unless there is documentation that the mother is HIV negative and the child does not have any risk factors for HIV (history of blood product transfusion, early sexual activity, or history of sexual violence or abuse). In most situations, complete and accurate information regarding risk factors will not be available. Therefore, most children less than 13 will need to be tested.
- Hepatitis B – since the majority of groups being resettled in the United States are from countries with intermediate or high levels of Hepatitis B endemicity testing should be performed as follows:
  - If an individual has received a dose of Hepatitis B vaccine in the last 30 days, testing for HBsAg should be deferred until at least 30 days have passed since receipt of the

- vaccine. In this case, testing should be deferred until the refugee comes back for his/her next set of immunizations.
- If no vaccine received in the last 30 days, all adults greater than 18 years of age should have the following testing:
    - Hepatitis B Surface Antigen (HBsAg) – this should be done regardless of vaccination history
    - Hepatitis B Core Antigen Antibodies (anti-HBc)
    - Hepatitis B Surface Antigen Antibodies (anti-HBs)
  - Children 18 years of age and younger should have the following testing:
    - Hepatitis B Surface Antigen (HBsAg) – this should be done regardless of vaccination history
    - Additional testing for children may be considered, if clinically appropriate
      - Call the NHP for consultation and approval for reimbursement
    - All children ≤18 should receive the complete 3 dose series of Hepatitis B vaccine.
  - Tuberculosis – all refugees should be screened, and if appropriate, tested for TB.
    - Districts may choose which method of testing they will use for assessing TB infection status:
      - TST
      - IGRA
      - Children less than 2 years of age should have a TST since IGRA use is not approved for this age group.
    - Individuals who are symptomatic should have additional appropriate testing including:
      - TST or IGRA
      - Chest x-ray
      - Sputum Collection
    - Individuals who have positive TSTs or IGRAs should receive appropriate follow up and treatment:
      - Chest x-ray
      - Treatment for LTBI as long as there is no evidence of active TB disease

### **Laboratory Testing for Certain Clients**

Perform lab testing for individuals meeting the following specified criteria.

- Cholesterol – can be done non-fasting
  - Men ≥35
  - Women ≥45
  - Men 20-35 and women 20-45 who are at risk for coronary artery disease (diabetics, tobacco users, hypertension, family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives, or a family history suggestive of familial hyperlipidemia)
- Pregnancy Testing for women of childbearing age

- Hepatitis C – test everyone born between 1945-1965 and those with any of the following risk factors:
  - Injection drug users – past and present
  - Individuals with body art including scars, tattoos or piercings
  - Individuals who may have been exposed to non-sterile or multi-use invasive medical devices
  - Individuals with HIV – these and other immunocompromised individuals may have false negative results and should be referred to a PCP for additional testing and follow-up
  - Blood or blood product recipients
  - Individuals with a history of multiple sex partners or STDs
- Syphilis Screening –If no documentation of overseas results:
  - Everyone  $\geq 15$
  - Children  $< 15$  if any of the following apply:
    - Sexually active or history of sexual assault
    - All at risk children (mother tests positive)
    - All refugees from countries\* that have endemic rates of other treponemal subspecies (yaws, bejel, pinta)
      - \*see List of Countries with Endemic Rates of Other Treponemal Sub-Species at the end of this document
- Chlamydia and Gonorrhea Urine Testing
  - Women  $\leq 25$  who are sexually active
  - Women  $> 25$  with risk factors (new sexual partner or multiple sexual partners)
  - All symptomatic refugees
- Serology –
  - Varicella
    - All refugees aged 19 and older – if no documentation of vaccination
  - MMR
    - All refugees aged 19 and older
      - Do not test if the individual has already received 1 or 2 doses of MMR.
- Blood Lead Level
  - All refugee children 6 months to 16 years of age
  - Refugee children 6 months to 6 years should have a blood lead level repeated 3-6 months after arrival to the U.S.
- Newborn Screening
  - All refugee children  $\leq 6$  months of age

## **Immunizations**

Provide age appropriate vaccines for all refugees per ACIP and CDC guidelines.

- Note - Zoster and HPV are no longer required for adjustment of status and will not be reimbursed by the NHP.

## **Other**

- Refugee Interpretation Services
  - Districts use this code for costs incurred by the LHD associated with the initial refugee health screening.
  - **This code may only be used and reimbursed 1 time per client.**
- Clinician Visit 2
  - Use this if a refugee needs to be seen for follow up by a clinician (ex. Abnormal lab results, etc)
- Nurse Visit
  - Use this if a refugee needs to be seen for follow up by the PHN (ex. Client returns for next set of immunizations.)
    - Note if immunization costs can be billed to Medicaid, LHDs should do so in lieu of submitting reimbursement to the Newcomer Health Program.

## **Medications**

- Refugees who need treatment for any of the below should be given a prescription with instructions to have it filled at a pharmacy of their choosing and use their Medicaid card.
  - O&P
    - Individuals who did not receive pre-departure treatment for ova and parasites should receive presumptive treatment, unless there is a contraindication.
    - Testing is also an option.
  - Malaria
    - Individuals who had contraindications to pre-departure treatment for malaria, but for whom the contraindication is no longer valid, should receive presumptive treatment.

## **Vitamins**

- Refugees who need vitamins should be given a prescription with instructions to have it filled at a pharmacy of their choosing and use their Medicaid card.
  - Children age 6-59 months
  - Consider giving vitamins to all refugees  $\geq 6$  years with clinical or laboratory evidence of poor nutrition



**\*List of Countries with Endemic Rates of Other Treponemal Sub-species  
(See Syphilis Screening Instructions)**

**REGION**

**COUNTRY**

**Africa**

Angola  
Benin  
Burkina Faso  
Cameroon  
Central African Republic  
Chad  
Cote d'Ivoire  
Democratic Republic of the Congo  
Ethiopia  
Gabon  
Ghana  
Liberia  
Mali  
Mauritania  
Niger  
Republic of the Congo  
Rwanda  
Senegal  
Somalia  
South Africa  
Sudan  
Togo

**Americas**

Colombia  
Ecuador  
Haiti  
Guyana  
Martinique  
Mexico  
Surinam  
Venezuela

**Asia**

Cambodia  
India  
Indonesia  
Pakistan  
Sri Lanka

**Middle East**

Saudi Arabia

**Western Pacific**

Papua New Guinea  
Solomon Islands  
Vanuatu

**Newcomer Health Program  
Initial Health Screening Report**

Place Patient Encounter Label Here: <b>Name (last, first):</b> _____  <b>DOB:</b> _____  <b>Pt#:</b> _____ (Web Vision or Avatar Number)	<b>Alien ID #:</b>	<b>Gender:</b>
	<b>Status:</b>	<b>Date of Arrival:</b>
	<b>Country of Origin:</b>	
	<b>Resettlement Agency:</b>	

<b>Was an initial health screening provided?</b> Yes    No	<b>If no screening provided, why?</b>
<b>Date of Health Screening:</b>	<b>Health District?</b>

<b>TB Classification</b>	Does the client have a Class A, B0, B1, B2, or B3 TB condition?    Yes    No
<b>Lead</b>	If age appropriate, was lead screening performed?    Yes    No    N/A If performed, was the lead result elevated?    Yes    No    N/A
<b>Mental Health</b>	Was a mental health screening performed?    Yes    No    N/A If yes, was the client referred for additional follow up?    Yes    No    N/A
<b>Parasitic Infections</b>	Was testing performed for parasitic infections? (not needed if treatment provided overseas)    Yes    No    N/A  Was <b>presumptive</b> treatment provided for any of the following: Schistosomiasis      Strongyloidiasis      Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms) Malaria                  No presumptive treatment provided
<b>HIV</b>	Was the client tested for HIV?    Yes    No                  HIV result:    Negative    Positive
<b>Tuberculosis</b>	Was a TST Provided?    Yes    No    TST Result:    Pos    Neg    N/A Was an IGRA drawn?    Yes    No    IGRA Result:    Pos    Neg    Borderline/Indeterminate    N/A Was treatment recommended for:    TB Disease    LTBI    Neither
<b>Hepatitis B</b>	Was a Hepatitis B Surface Antigen Drawn?    Yes    No Was the Hepatitis B Surface Antigen:    Normal    Abnormal
<b>Hepatitis C</b>	Was Hepatitis C (HCV antibody) performed?    Yes    No Was the Hepatitis C antibody:    Normal    Abnormal
<b>STI</b>	Was the client tested for: Syphilis?    Yes    No                  Chlamydia?    Yes    No                  Gonorrhea?    Yes    No Treatment needed for: Syphilis?    Yes    No                  Chlamydia?    Yes    No                  Gonorrhea?    Yes    No
<b>Primary Care</b>	Was the client referred to primary care?    Yes    No

**Person Completing Form:** \_\_\_\_\_ **Phone # :** \_\_\_\_\_

Print Name (Last Name, First Name)

Please **FAX** completed forms to the Newcomer Health Program at (804)864-7913  
Retain original in client record

Forms **MUST** be returned within 30 days of assessment in order for the LHD to receive reimbursement.

Revised 10/2019

## Newcomer Health Program

### Follow-Up Vaccine Form

**Affix a patient label**, or complete the information below:

**Name:** \_\_\_\_\_ **Web Vision /Patient ID#** \_\_\_\_\_  
(Last name, First name)

**DOB:** \_\_\_\_\_ **Alien ID#** \_\_\_\_\_

**Health District:** \_\_\_\_\_

**Date of Arrival to US** \_\_\_\_\_ (use date asylum granted for aylees)

\*\*\*\*Reminder reimbursement is only available for 1 year from the date of admission/date asylum granted

**Date vaccines administered:** \_\_\_\_\_

**Vaccines administered:** ☐Td/Tdap ☐MMR ☐Varicella ☐Flu ☐Pneumococcal

**Did your district complete the initial health screening for this patient?** ☐Yes ☐No

**If no, was the initial health screening completed in VA?** ☐Yes ☐No

**If the initial health screening was NOT completed in VA, where was it completed?** \_\_\_\_\_

This form should be used whenever districts are providing additional vaccines (after the initial health screening) to refugees or other qualified individuals (asylees, etc.). Please provide all of the requested information above and fax to the NHP at (804)864-7913 along with your other documentation.

**\*\*Reminder: The Newcomer Health Program is unable to provide reimbursement for the following vaccines or associated costs: Hepatitis A or B, HPV, Meningococcal, Zoster.**

**\*Costs associated with vaccines for children, including administration fees, should be billed to Medicaid.**

Do not fax, retain in records.

### Lab Results

LABS			COMMENTS
<b>CBC</b>	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done Hgb:_____
<b>Basic Metabolic Profile</b>	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done
<b>Urinalysis</b>	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done
<b>HIV</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done
<b>Hepatitis B</b>	<b>Surface Antigen</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
	<b>Immune</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Cholesterol</b>	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done/N/A
<b>UPT</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
<b>Blood Lead Level</b>	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done/N/A _____ug/dl
<b>Hepatitis C</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
<b>RPR</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
<b>Chlamydia/GC</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
<b>Varicella IgG</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal		<input type="checkbox"/> Not done/N/A
<b>MMR</b>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/Equivocal		<input type="checkbox"/> Not done/N/A

### TB Screening/Testing Results

<b>IGRA</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TSpot <input type="checkbox"/> QFT Date:_____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/Equivocal
<b>TST</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Applied:_____ Date Read:_____	Result:_____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<b>Chest x-ray</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Not done/N/A
<b>Treatment</b>	<input type="checkbox"/> Active Disease <input type="checkbox"/> LTBI <input type="checkbox"/> No Treatment	Comments:

Place Patient label here

## Instructions for Using the Newcomer Health Initial Health Screening Results Form

1. Place a patient label in the lower right hand corner of the form.
2. Place an (X) next to the appropriate box to indicate whether or not the CBC, Basic Metabolic Profile, Urinalysis, Cholesterol, and Blood Lead Level are within normal limits. For those tests not done, place an (X) next to the Not done/N/A box.
3. Indicate with an (X) whether the HIV, UPT, Hepatitis C, RPR, and Chlamydia/GC result is positive, negative, or not done. For those tests not done, place an (X) next to the Not done/N/A box.
4. Indicate with an (X) whether the Hepatitis B Surface Antigen was positive or negative. Indicate with an (X) whether the person is immune or not immune to Hepatitis B. If testing was not performed or not applicable, place an (X) next to the not done/N/A box.
5. Indicate with an (X) whether the Varicella IgG and MMR serology was positive, negative or equivocal/borderline. If testing was not performed or not applicable, place an (X) next to the not done/N/A box. **Positive serology results should be recorded in Web Vision. You can do this by using the contraindications screen, selecting the appropriate disease, and the selection “serological confirmation”.** Putting these results in Web Vision is helpful when clients move between districts.
6. Use the Comments section to record any specific information. (Hgb., blood lead level, etc)
7. Indicate with an (X) whether or not an IGRA was done.
  - a. Indicate with an (X) which IGRA was used.
  - b. Record the date the IGRA was drawn.
  - c. Indicate with an (X) whether the IGRA result was positive, negative, or borderline/equivocal.
8. Indicate with an (X) whether or not a TST was done.
  - a. Complete the date applied, the date read, and the numerical result in mm.
  - b. Indicate with an (X) whether the result is considered positive or negative.
9. Indicate with an (X) whether the chest x-ray was normal or abnormal. If a chest x-ray was not done or not applicable, place an (X) next to the not done/N/A box.
10. Indicate with an (X) whether treatment was recommended for active TB disease or LTBI. If treatment was not recommended, place an (X) next to the no treatment box.

Patient Label

## CHECK BELOW IF YOU OR ANY FAMILY MEMBER HAVE THESE:

	YOU	FAMILY		YOU	FAMILY	OFFICE USE ONLY
1. Allergies (food/drug/latex/insects/seasonal)			19. Genetic Diseases			
2. Anemia (low blood iron)/sickle cell or trait			20. Heart Problems/Murmurs			
3. Asthma or bronchitis			21. Hepatitis or liver disease			
4. Arthritis			22. High blood pressure			
5. Birth Defects			23. HIV/Sexually Transmitted Infection			
6. Bladder/Kidney Problems			24. Intellectual disability/Learning problems			
7. Blood clots (legs or lungs)			25. Mental illness/Depression/Depression after birth			
8. Blood disease or bleeding			26. Migraine headache			
9. Bone problems			27. Muscle/Joint problems			
10. Cancer			29. Organ Transplant			
11. Deafness/Ear problems/Tubes			29. Skin problems			
12. Dental Problems			30. Stroke			
13. Diabetes (sugar)			31. Suicide/thoughts/attempt			
14. Diarrhea/Constipation/Bowel Problem			32. Thyroid problems			
15. Eating of non-food items			33. Throat problems			
16. Epilepsy/Seizures			34. Tuberculosis/other lung problem			
17. Feeding Problems/Special Diet			35. Vision/Eye problem			
18. Gall Bladder Problems			36. Other_____			

G\_\_\_\_P\_\_\_\_A\_\_\_\_ LMP:\_\_\_\_\_ If Pregnant EDD:\_\_\_\_\_ Breastfeeding YES\_\_\_\_ NO\_\_\_\_ Birth Control Method\_\_\_\_\_

Have you ever been hospitalized? YES\_\_\_\_ NO\_\_\_\_ If YES; List dates and why\_\_\_\_\_

Do you drink alcohol/beer/wine/liquor? YES\_\_\_\_ NO\_\_\_\_ If YES, how much?\_\_\_\_\_

Do you use cigarettes/tobacco products? YES\_\_\_\_ NO\_\_\_\_ If YES, how much?\_\_\_\_\_ Quit Now Referral? YES\_\_\_\_ NO\_\_\_\_

Do you use other drugs? YES\_\_\_\_ NO\_\_\_\_ If YES, what?\_\_\_\_\_

Do you have any tattoos/body art/body piercings/traditional or tribal scars or markings? YES\_\_\_\_ NO\_\_\_\_ Describe:\_\_\_\_\_

TNF Alpha Blockers? YES\_\_\_\_ NO\_\_\_\_ List any other medications: \_\_\_\_\_

Do you use any traditional herbs or remedies? YES\_\_\_\_ NO\_\_\_\_ If YES, what and how often? \_\_\_\_\_

Current Occupation/School: \_\_\_\_\_

Do you live in house\_\_\_\_ apartment\_\_\_\_ mobile home\_\_\_\_ motel\_\_\_\_ shelter\_\_\_\_ other\_\_\_\_? Number of persons living there: \_\_\_\_\_

Signature of person completing form: \_\_\_\_\_

VDH TB 03/2019

Date: \_\_\_\_\_

## **Instructions for Using the TB and Newcomer Health History**

TB and Newcomer Health History – Health history information should be gathered and reviewed by the nurse case manager and clinician for all clients. The TB Program and Newcomer Health Program share the same health history form.

- Place a client label in the client label box. In the absence of a label, write-in the client's name and date of birth.
- Indicate with an (X) whether the individual or individual's family member has/had any of the conditions listed.
- Use the "other" box (#36) to indicate the presence of any problem/illness not listed.
- Use the open area to the right under "Office Use Only" to provide specific information about conditions of concern for both the client and family members. Use a progress note if there is not enough space.
- For women, indicate G/P/A status, LMP, estimated date of delivery (if applicable), if she is breast feeding, and record method of birth control.
- Indicate with an (X) if the client has ever been hospitalized. List date(s) and reason(s) why.
- Indicate with an (X) if the client drinks any alcohol, beer, wine, or liquor. Note how much the client drinks.
- Indicate with an (X) if the client uses any cigarette, tobacco, or vaping products. Note how much the client uses. Indicate whether a referral to Quit Now was provided.
- Indicate with an (X) if the client uses other drugs. Note what drug used.
- Indicate with an (X) if the client has any tattoos, body art, body piercings, traditional or tribal scars or markings. Describe any body art etc. that is present.
- Indicate with an (X) if the client is on any TNF Alpha blockers.
- List any medications the client is taking. Complete medication information should be listed on the Medication List.
- Indicate with an (X) if the client uses any traditional herbs or remedies. List what the client uses and how often.
- Indicate the client's current occupation or school.
- Indicate with an (X) the type of residence in which the client lives.
- Indicate the number of people living in the client's home.
- Sign and date the form.

Date of Exam: \_\_\_\_\_ Age: \_\_\_\_\_ BMI: \_\_\_\_\_  
Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp. Rate: \_\_\_\_\_ Head Circ.: \_\_\_\_\_

BODY SYSTEM	Abnormalities noted?		FINDINGS/COMMENTS
	YES	NO	
Skin			
Head			
Eyes/Vision			Rt. Eye _____ Lt. Eye _____ Both eyes _____
ENT/Hearing			Whisper Test: Pass _____ Fail _____
Oral Cavity/Teeth			
Heart			
Lung			
Abdomen			
Liver or Spleen Enlargement			
Lymph Nodes			
Musculoskeletal			
Extremities			
Neurological			
Genital			

Indicate with an "X" whether or not any abnormalities are noted for each body system.

**Person Completing Physical Exam/Assessment:**

\_\_\_\_\_  
(Printed Name and Title)

\_\_\_\_\_  
(Signature)

**Referrals:**

- ☐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

Place Patient label here



**Instructions for Using the Newcomer Health  
Initial Health Screening Physical Exam/Assessment Form**

1. Place a patient label in the lower right hand corner of the form.
2. Date of Exam – this should be the date the actual physical exam/assessment occurred.
3. Fill in age, BMI, height, weight, blood pressure, pulse, and respiratory rate for all patients. Head circumference should be completed for children less than 2 years of age.
4. Place an (X) under the appropriate box, yes if an abnormality is noted and no if an abnormality is not noted, for each body system. Use the comments section to record specific information. If additional space is needed, use a separate progress notes page.
5. Print and sign the name and title of the person completing the exam/assessment.
6. Place an (X) next to the box for any referrals that are made as a result of the initial health screening.
7. Indicate with an (X) whether or not the individual was linked/referred to a primary care provider.

NEWCOMER HEALTH PROGRAM  
HEALTHCARE PROVIDER SIGNATURE SHEET

SIGNATURE/TITLE	PRINTED NAME/TITLE

Place Patient label here