Fax to Newcomer Health Program and retain in records

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

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. **Status** (circle 1) Refugee Asylee SIV Cuban/Haitian T-Visa

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)

Forms **MUST** be returned within 30 days of assessment in order for the LHD to receive reimbursement.
Please **FAX** completed forms to the Newcomer Health Program at (804)864-7913