Newcomer Health Program
Initial Health Screening Report

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

Was an initial health screening provided? ☐ Yes ☐ No	**If no screening provided, why?**
Date of Health Screening:	**Health District?**

TB Classification	Does the client have a Class A, B0, B1, B2, or B3 TB condition? ☐Yes ☐No
Lead	If age appropriate, was lead screening performed? ☐ Yes ☐No ☐N/A If performed, was the lead result elevated? ☐ Yes ☐No ☐N/A
Mental Health	Was a mental health screening performed? ☐ Yes ☐No ☐N/A If yes, was the client referred for additional follow up? ☐ Yes ☐No ☐N/A
Parasitic Infections	Was testing performed for parasitic infections? (not needed if treatment provided overseas) ☐Yes ☐No ☐N/A Was ***presumptive*** treatment provided for any of the following: ☐Schistosomiasis ☐Strongyloidiasis ☐Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms) ☐Malaria ☐ No presumptive treatment provided
HIV	Was the client tested for HIV? ☐Yes ☐No HIV result: ☐Negative ☐Positive
Tuberculosis	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
Hepatitis B	Was a Hepatitis B Surface Antigen Drawn? ☐Yes ☐No Was the Hepatitis B Surface Antigen: ☐Normal ☐Abnormal
Hepatitis C	Was Hepatitis C (HCV antibody) performed? ☐Yes ☐No Was the Hepatitis C antibody: ☐Normal ☐Abnormal
STI	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
Primary Care	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