Instructions for Initial Health Screening Report

1. Place a patient label in the top left corner or complete all information by hand
2. Write in Alien ID # - this is required for reimbursement to be processed
3. Indicate the client's gender
4. Indicate the client's visa status (refugee, asylee, etc.)
5. Indicate the client's date of arrival to the U.S.
6. Indicate the client's country of origin
7. Indicate the resettlement agency assisting the client (if applicable)
8. Indicate whether or not a health screening was provided
9. If a screening was not provided indicate the reason why (moved, never located, missed multiple appointments, refused, screened by another provider, unknown, other, n/a – had screening)
10. Indicate the date of the health screening
11. Provide the name of the health district/Organization who performed the screening
12. Indicate whether or not the client has any TB classified conditions
13. Indicate whether or not lead screening was performed and whether or not the result was elevated
14. Indicate whether or not a mental health screening was performed and whether or not the client was referred for additional follow-up
15. Indicate whether or not testing was performed for parasitic infections
16. Indicate whether or not presumptive treatment was provided for listed conditions
17. Indicate whether or not HIV testing was performed and the result
18. Indicate whether or not a TST was provided and the result
19. Indicate whether or not an IGRA was drawn and the result
20. Indicate whether or not treatment was recommended for TB disease or LTBI
21. Indicate whether or not a Hepatitis B surface antigen was drawn and the result
22. Indicate whether or not a Hepatitis C surface antigen was drawn and the result
23. Indicate whether or not the client was tested for Syphilis, Chlamydia, or Gonorrhea and whether or not treatment was needed
24. Indicate whether or not the client was referred to primary care
25. Indicate whether or not the client was tested for CBC, BMP, U/A, Pregnancy Test, or CXR
26. Indicate whether or not any services (Labs, H&P, etc.) billed to Medicaid
27. Indicate the name of the person completing the form and their phone number