VIRGINIA DEPARTMENT OF HEALTH

Screening Instructions and Forms

Newcomer Health Program

VDH VIRGINIA DEPARTMENT OF HEALTH

Protecting You and Your Environment

www.vdh.virginia.gov

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) and instructions
-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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Virginia Department of Health
804-864-7911
804-864-7913 (FAX)
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Newcomer Health Encounter Form

Place encounter label here: Date:_____

Name:_____

DOB:_____ Pt #:_____

Encounter #_____

Subprogram: RF
Setting: _____

Diagnosis Code: Z02.89
ORG ID: 135807260

Provider #_____ Provider Time:_____
Provider #_____ Provider Time:_____

HISTORY AND PHYSICAL EXAM/ASSESSMENT

☐ Performed by MD
☐ Performed by NP*
☐ Performed by PHN†

99381 ☐ H&PA <I 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

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 Screening and Diagnosis 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.

L144473 ☐ Hepatitis B Screening and Diagnosis
L6510 ☐ Hepatitis B surface antigen

Lab Charges

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

Updated: 7/6/2022

TB TESTING

L182913 ☐ QuantiFERON TB Gold Plus 1 tube
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

Serum Chemistries

Indicated based on signs/symptoms and comorbidities; Uric acid recommended for Hmong refugees

L322758 ☐ Basic metabolic panel

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

Choose 717009 for children ≤16 years; > 16 years if high index of suspicion, or clinical symptoms of lead exposure; All pregnant and lactating women and girls

L717009 ☐ Assay of lead

Hepatitis C Testing

All new adult refugees; all pregnant women during each pregnancy

L144050 ☐ 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

If no documentation, 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£ Free/Charge

90651 ☐ HPV9

90713 ☐ IPV£

90696 ☐ Kinrix (DTaP/IPV)

90734 ☐ MCV4

90707 ☐ MMR£ Free/Charge

90710 ☐ MMRV

90670 ☐ PCV13£

90723 ☐ Pediarix (DTaP/IPV/Hep-B)

90698 ☐ Pentacel (DTaP/IPV/Hib)

90732 ☐ PPV23£

90681 ☐ Rotarix

90680 ☐ Rotateq

90714 ☐ Td£ Free/Charge

90715 ☐ Tdap£ Free/Charge

90716 ☐ Varicella£ Free/Charge

90697 ☐ Vaxelis (DTaP/IPV/HIB/HepB)

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 include the appropriate Diagnosis code (B78 – Strongyloidiasis, B89 – unspecified intestinal parasite, B73 Onchocerciasis)**

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 or email jill.grumbine@vdh.virginia.gov.

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: 7/6/2022

£ = 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 endemnicity 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 ≥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 ≤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 ≤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 ≥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: Name (last, first):_____ DOB:_____ Pt#:_____ (Web Vision or Avatar Number)	Alien ID #:	Gender:
	Admission Status:	Date of Arrival to US:
	Country of Origin:	
	Resettlement Agency/Sponsor:	

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

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 ☐ Other, Please Specify: _____
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
Testing (indicate which procedures the patient had)	☐ CBC ☐ BMP ☐ U/A ☐ Pregnancy Test ☐ CXR
Billing	Were any services (Labs, H&P, etc.) billed to Medicaid? ☐ Yes ☐ No

Person Completing Form:_____ **Phone #** :(____)_____

Forms **MUST** be returned by encrypted email or fax (804-864-7913) by the 20th of the month following the screening date
(i.e. January screening forms must be submitted by February 20.) Retain the original in the client's record.

Revised 04/2022

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, 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

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 asylees)

****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

☐ Hep B ☐ Polio

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, 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
CBC	WNL?	☐Yes ☐No	☐Not done Hgb:_____
Basic Metabolic Profile	WNL?	☐Yes ☐No	☐Not done
Urinalysis	WNL?	☐Yes ☐No	☐Not done
HIV	☐Positive ☐Negative		☐Not done
Hepatitis B	**Surface Antigen** ☐Positive ☐Negative **Immune** ☐Yes ☐No		☐Not done/N/A
Cholesterol	WNL?	☐Yes ☐No	☐Not done/N/A
UPT	☐Positive ☐Negative		☐Not done/N/A
Blood Lead Level	WNL?	☐Yes ☐No	☐Not done/N/A _____ug/dl
Hepatitis C	☐Positive ☐Negative		☐Not done/N/A
RPR	☐Positive ☐Negative		☐Not done/N/A
Chlamydia/GC	☐Positive ☐Negative		☐Not done/N/A
Varicella IgG	☐Positive ☐Negative ☐Equivocal		☐Not done/N/A
MMR	☐Positive ☐Negative ☐Borderline/Equivocal		☐Not done/N/A

TB Screening/Testing Results

IGRA ☐Yes ☐No	☐TSpot ☐QFT Date:_____	Result: ☐Positive ☐Negative ☐Borderline/Equivocal
TST ☐Yes ☐No	Date Applied:_____ Date Read:_____	Result:_____ mm ☐Positive ☐Negative
Chest x-ray	☐Normal ☐Abnormal	☐Not done/N/A
Treatment	☐Active Disease ☐LTBI ☐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.

TB and Newcomer Health History

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 12/2020

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.

Do not fax, retain in records

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