Newcomer Health Program
Initial Screening Report

Place Patient Encounter Label Here: Name (last, first):_____ DOB:_____ Pt#:_____ (Web Vision or Avatar Number)	*Alien ID #:	Gender: ☐M ☐F
	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 health screening started: _____ Date health screening completed: _____	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 appropriate, was lead screening performed? ☐N/A ☐Yes ☐No If performed, was the lead result elevated? ☐N/A ☐Yes ☐No
Mental Health	Was a mental health screening performed? ☐N/A ☐Yes ☐No If yes, was the client referred for additional follow-up? ☐N/A ☐Yes ☐No
Parasitic Infections	Was testing performed for any of the following? ☐No Testing Performed ☐Schistosomiasis ☐Strongyloidiasis ☐Malaria ☐Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms) Was ***presumptive*** treatment provided for any of the following? ☐No Presumptive Treatment ☐Schistosomiasis ☐Strongyloidiasis ☐Malaria ☐Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms)
HIV	Was the client tested for HIV? ☐Yes ☐No HIV Result: ☐Neg ☐Pos
Tuberculosis	Was an IGRA drawn? ☐Yes ☐No IGRA Result: ☐Pos ☐Neg ☐Borderline/Indeterminate ☐N/A
	Was a TST administered? ☐Yes ☐No TST Result: ☐Pos ☐Neg ☐N/A
	Was treatment recommended for: ☐TB Disease ☐LTBI ☐Neither
Hepatitis B	Was Hepatitis B Surface Antigen Testing performed? (by itself or as part of a panel)? ☐Yes ☐No Hepatitis B Surface Antigen result: ☐Normal ☐Abnormal
Hepatitis C	Was Hepatitis C Antibody testing performed? ☐Yes ☐No Hepatitis C Antibody result: ☐Normal ☐Abnormal
STI	Was the client tested for: Syphilis? ☐Yes ☐No Chlamydia? ☐Yes ☐No Gonorrhea? ☐Yes ☐No Was 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 ☐Urine dipstick or U/A ☐Pregnancy Test ☐CXR
Billing	Were any services (Labs, H&P, etc.) billed to Medicaid? ☐Yes ☐No

*Alien ID Number, Passport Number, or I-94 number MUST be provided before reimbursement can be provided.

Person Completing Form:_____ Phone:_____

Forms **MUST** be returned by encrypted email (newcomerhealth@vdh.virginia.gov) or fax (804-315-8185) by the 15th of the month following the screening date (i.e. January screening forms must be submitted by February 15th.) Retain the original in the client's record.

Revised 06/09/2026