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: ☐ 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 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 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 ☐ Strongyloides ☐ Malaria ☐ Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms) Was ***presumptive*** treatment provided for any of the following? ☐ No presumptive treatment provided ☐ Schistosomiasis ☐ Strongyloides ☐ Malaria ☐ Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms)
HIV	Was the client tested for HIV? ☐ Yes ☐ No HIV Result: ☐ Neg ☐ Pos
Tuberculosis	Was a TST administered? ☐ 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 Hepatitis B Surface Antigen Testing performed? (by itself or as part of a panel)? ☐ Yes ☐ No Was the Hepatitis B Surface Antigen result: ☐ Normal (Neg) ☐ Abnormal (Pos)
Hepatitis C	Was Hepatitis C (HCV antibody) performed? ☐ Yes ☐ No Was the Hepatitis C antibody: ☐ Normal (Neg) ☐ Abnormal (Pos)
STI	Was the client tested for any of the following? Syphilis ☐ Yes ☐ No Chlamydia: ☐ Yes ☐ No Gonorrhea ☐ Yes ☐ No Was treatment needed for any of the following? 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, vaccines, etc.) billed to Medicaid? ☐ Yes ☐ No

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

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

Forms **MUST** be sent by fax (804)864-7913 or by encrypted email to newcomerhealth@vdh.virginia.gov by the 20th of the month following the screening date (i.e. January screening forms must be submitted by February 20th, etc.). Retain the original in the client's record.

Revised 02/05/2024