Newcomer Health Program
Initial Screening Report

| Place Patient Encounter Label Here:<br>Name (last, first):_____<br>DOB:_____<br>Pt#:_____<br>(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: _____<br>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<br>If performed, was the lead result elevated? ☐N/A ☐Yes ☐No |
| **Mental Health** | Was a mental health screening performed? ☐N/A ☐Yes ☐No<br>If yes, was the client referred for additional follow-up? ☐N/A ☐Yes ☐No |
| **Parasitic Infections** | Was testing performed for any of the following?<br>☐No Testing Performed ☐Schistosomiasis ☐Strongyloidiasis<br>☐Malaria ☐Soil Transmitted Helminths (Ascaris lumbricoides, trichuris trichiura, hookworms)<br>Was ***presumptive*** treatment provided for any of the following?<br>☐No Presumptive Treatment ☐Schistosomiasis ☐Strongyloidiasis<br>☐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<br>Hepatitis B Surface Antigen result: ☐Normal ☐Abnormal |
| **Hepatitis C** | Was Hepatitis C Antibody testing performed? ☐Yes ☐No<br>Hepatitis C Antibody result: ☐Normal ☐Abnormal |
| **STI** | Was the client tested for:<br>Syphilis? ☐Yes ☐No Chlamydia? ☐Yes ☐No Gonorrhea? ☐Yes ☐No<br>Was treatment needed for:<br>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 09/10/2025