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

Revised 9/13/2024