MASSACHUSETTS REFUGEE HEALTH ASSESSMENT PROGRAM (RHAP)
REFUGEE HEALTH ASSESSMENT FORM

Save As

Family Name: First & Mid: MAVEN ID:

Birth Date: Sex: ☐ M ☐ F Arrival Date: ☐ Asylee? A#:

Address: Tel:

Nationality: Resettlement Agency:

Overseas Medical Examination

DS-2054 Reviewed: ☐ Yes ☐ No Class A/B conditions: ☐ None ☐ A ☐ B TB ☐ B Other ☐ No overseas documents

IOM Bag Reviewed: ☐ Yes ☐ No Pre-departure Presumptive Treatment?: ☐ Antimalarial ☐ Antihelminthic ☐ Unknown

Tuberculosis

TST (mm): Plant Date: Read Date: Overseas chest X-ray: ☐ NL ☐ ABNL BCG:

IGRA Type: ☐ QuantiFERON ☐ T-Spot Date: Result: ☐ Negative ☐ Positive ☐ Indeterminate/Borderline

Hepatitis B

HBsAg: ☐ Neg ☐ Pos AntiHBs: ☐ Neg ☐ Pos **AntiHBcAb:** Neg Pos

HIV

HIV-1 antibody: ☐ Neg ☐ Pos ☐ Offered, but refused HIV-2 antibody: ☐ Neg ☐ Pos ☐ Offered, but refused

Intestinal Parasites: *Record treatment in the "medications prescribed" section.*

Giardia FAb: ☐ Neg ☐ Pos ☐ Stool Not Returned Stool O&P Done? ☐ Yes ☐ No

☐ None ☐ Ascaris ☐ Blastocystis ☐ E. histolytica ☐ Giardia ☐ H. nana ☐ Hookworm ☐ Strongyloides ☐ Trichuris ☐ Other

Immunizations: *Attach immunization record or fill in the table on page 2. Record ALL valid doses for which you have documentation.*

Varicella Titer: ☐ Neg ☐ Pos Immune by: ☐ Exam ☐ History

Basic Health Screening ☐ H&P Done

	NL ABNL	Wgt (lb):	Hgt (in):	BP:	Hgb:	MCV:
Vision:	☐ ☐		WBC:	EOS (%):	Plt Ct:	Pb:
Hearing:	☐ ☐	UA Sugar:	UA Protein:	UA Blood:	uHCG1: ☐ Neg ☐ Pos	uHCG 2: ☐ Neg ☐ Pos
Dental:	☐ ☐	Tob. Use: ☐ Yes ☐ No	Alc. Use: ☐ Yes ☐ No	RHS-15 Q1-14: /56	Distress Therm: /10	

Other Diagnoses	Medications Prescribed	Health Education
1.	1.	☐ Vaccines ☐ Access to care
2.	2.	☐ Primary Care ☐ Insurance
3.	3.	☐ Oral Health ☐ Emergencies
4.	4.	
5.	5.	☐ MVI Dispensed ☐ Vit D TX

Domestic Presumptive Treatments: *Record treatment in the "medications prescribed" section.* ☐ Antimalarial ☐ Antihelminthic

Referrals

Primary Care - Site: Clinician Name: PCP Appt dt:

☐ Cardiology ☐ Dental ☐ Dermatology ☐ Disability Svcs ☐ Endocrinology ☐ ENT ☐ GI ☐ ID ☐ Hem/Onc ☐ Mental Hlth

☐ Neurology ☐ OB/GYN ☐ Orthopedics ☐ TB Clinic ☐ Vision ☐ WIC ☐ Other:

Comments:

CLINICIAN: INTERPRETER: None: ☐

RHAP SITE: Appt1: Appt2: MR#:

RETURN COMPLETED FORM TO:

Division of Global Populations and Infectious Disease Prevention, MDPH
305 South Street, Jamaica Plain, MA 02130 Tel: 617-983-6590 FAX: 617-983-6597

Revised: October, 2017

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REFUGEE HEALTH ASSESSMENT FORM - Page 2

Family Name: _____ First & Mid: _____ Birth Date: _____

Immunizations: *Attach immunization record or fill in the table below. Record ALL valid doses for which you have documentation.*

	Date	Date	Date	Date	Date	Date
DTaP/DTP:						
Tdap:						
Td:						
Hepatitis A:						
Hepatitis B:						
HiB:						
HPV:						
Influenza:						
Meningoccocal:						
MMR:						
Measles:						
Mumps:						
Rubella:						
Pneumococcal:	☐ PCV7 ☐ PCV13 ☐ PCV23					
Rotavirus:						
Varicella/Zoster:						
IPV/OPV						