

## Instructions to complete the DHMH Refugee Health Assessment Summary

### Purpose of this Document

The purpose of this document is for the health care provider to communicate and summarize findings from the refugee health assessment, as well as identify next steps so that there is continuity of health care for the refugee/asylee client.

### Timing/Distribution

At the conclusion of the health assessment, the provider should complete both the English version of this document and also the translated version corresponding to the client's language. The layout is the same for the English and translated versions, so the health care provider should be able to check the appropriate and corresponding boxes on the translated version as well as write in any necessary information (in English). The translated version should be provided to the client, and the English version should be forwarded to the client's case manager (a copy should also be retained by the health care provider). If the document is not available in the client's language, please provide them with a copy of the English version.

### Demographics

Provide information on name, gender, alien number, date of birth, address, sponsor name and phone #, case manager name and phone #, agency performing health assessment, resettlement/volunteer agency (e.g. IRC, LIRS, etc.), date of arrival in the U.S., country of birth, and name of the physician or nurse who performed the health assessment.

### Assessment Findings

1. Diagnosis: Select all that apply.
2. Labs Ordered: Select all that apply.
3. Lab Results: Attach a print out (from MIRIS) of the Refugee Health Assessment Form.
4. Immunizations administered: Select all that apply.
5. Immunization titers: Select all that apply.

### Referrals

Select all that apply. If further TB evaluation is warranted, please note the name of the local health department (LHD) or referral center. If specialist or other follow-up services are recommended, please note the type of specialty health care that is needed **AND** indicate how soon the client should have a follow-up appointment. This information will assist the client's case manager in making any necessary follow-up appointments in a timely manner.

### Medications

Please select 'yes' or 'no' in response to the question 'Medications prescribed?' and provide a list of these prescribed medications. Please write this information legibly and attach any prescriptions. Please check the appropriate Maryland Medicaid HealthChoice Managed Care Organization (MCO) formulary to ensure that the prescribed medications are covered. The MCO formularies are now available on line through the Epocrates system. Registration for Epocrates is free and is available at [www.epocrates.com](http://www.epocrates.com). Alternatively, you can go to: <http://www.mdmahealthchoicex.com/mdf/bdmdf/formularies.htm>, however the most up-to-date information will be found on Epocrates.

### Next Steps

Please select all that apply. Please ensure that if another appointment is scheduled with your clinic, that you include the date, time, and purpose, as well as the contact phone number.

### Notes

Please include any pertinent notes relating to the client's current health status and follow-up.

*The health care provider filling out the Summary must print and sign their name as well as include the date at the bottom of the page.*