INITIAL REFUGEE HEALTH ASSESSMENT FORM: GUIDELINES FOR COMPLETION

Connecticut Department of Public Health
Refugee and Immigrant Health Program

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TABLE OF CONTENTS

	PAGE
Acronym List	**2**
Preface	**3**
SECTION I: Introduction to the Refugee Resettlement System and the Initial Domestic Refugee Health Assessment	**4**
SECTION II: Components of the Initial Domestic Refugee Health Assessment	**5**
SECTION III: Guidelines for Completion and Distribution of the initial Domestic Refugee Health Assessment Form	**6**
SECTION IV: Acknowledgements; Contact Information; CLAS Standards #4-7; References Cited	**13**

ACRONYM LIST (selected)

ACIP	Advisory Committee on Immunization Practices
CBC	complete blood count
CDC	Centers for Disease Control and Prevention
CLAS	National Standards for Culturally and Linguistically Appropriate Services in Health Care
DPH	Connecticut Department of Public Health
DSS	Connecticut Department of Social Services
EDN	Electronic Disease Notification System
HIV	human immunodeficiency virus
IGRA	interferon gamma-release assay
LTBI	latent TB infection
ORR	Office of Refugee Resettlement
PPD	purified protein derivative
RHA	Refugee Health Assessment
RRA	Refugee resettlement agency
RIHP	Connecticut Refugee and Immigrant Health Program
STD/STI	sexually transmitted diseases/infections
TB	tuberculosis
TST	tuberculin skin test
UNHCR	United Nations High Commission on Refugees

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PREFACE

The **purpose** of this document is to provide health care providers, local health departments, and refugee resettlement agency (RRA) staff guidance for completion of the *Initial Refugee Health Assessment Form* (RHA form), revised in 2013 by the Connecticut Refugee and Immigrant Health Program (RIHP). It is designed as a "middle ground" document that offers more detail than the *RHA Pocket Guide*, and less detail than the *Centers for Disease Control and Prevention (CDC) Guidelines Binder* that form the full set of resources for the RHA form.

The **audience** for this document includes all persons involved in guiding a newly-arrived refugee entrant through the domestic RHA process. This may include: refugee resettlement agency (RRA) staff, health care providers, local health departments, and state agency staff.

- As part of the resettlement process, **RRAs** are required to: 1) guide newly-arrived refugees through the initial RHA process (including, e.g., making initial appointments, arranging interpretation and transportation), and 2) to arrange to return the initial RHA forms to the Connecticut Department of Public Health (DPH).

- **Medical providers, including local health departments**, are requested to: 1) conduct RHAs for newly-arriving refugees, 2) complete the RHA form with all appropriate information and return it to the RIHP or an RRA case manager, and 3) refer refugee clients to appropriate follow-up services and primary care or medical home providers.

- The **RIHP Coordinator at DPH**: 1) provides up-to-date RHA materials and technical support for RRAs and medical providers, and 2) collects, analyzes and reports data to the Office of Refugee Resettlement (ORR) and CDC, as well as to state agencies, local health providers, and RRAs.

This guidelines document is divided into **four sections**:

- Introduction to the refugee resettlement system and initial RHA
- General description of components of the initial domestic RHA
- Guidelines and line-by-line instructions for completion of the RHA Form (includes: Part 1-Demographic Information, Part 2-Screening/Test Results, Part 3-Provider Information, and directions for distribution of the RHA form/ general record-keeping)
- Contact and Reference Information. An Acronym List is provided in the front of the document.

SECTION I: INTRODUCTION TO THE REFUGEE RESETTLEMENT SYSTEM AND THE INITIAL DOMESTIC REFUGEE HEALTH ASSESSMENT

In 1951, the *Convention Relating to the Status of Refugees* was adopted by a United Nations diplomatic conference. This document, and the amendments to it set forth in the *1967 Protocol*, have framed the way that the international community defines, protects, treats, and resettles refugees (United Nations High Commission on Refugees [UNHCR], September 2011).

According to the ORR (ORR, Who We Serve), a "refugee" is someone:

> "who is outside any country of such person's nationality...and who is unable or unwilling to return to...that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion…"

The ORR definition includes persons formally designated as refugees, asylees, victims of human trafficking, certain entrants from Vietnam, Cuban and Haitian entrants, and certain entrants from Iraq and Afghanistan. In the United States, the passage of The Refugee Act of 1980, which "standardized the resettlement services for all refugees admitted to the U.S.,…ma[de] provision[s] for regular flow as well as emergency admission of refugees, and authorize[d] federal assistance for the resettlement of refugees" (ORR 2011, History). Each year, approximately 50,000-75,000 refugees are settled in the U.S. (though these figures have ranged from a high of 207,116 in 1980 to a low of 27,100 in 2002 [ORR 2011, History]). In the last 10 years, Connecticut has resettled an annual average of 440 persons classified as refugees (CT Department of Social Services [DSS] Refugee Assistance Program).

The CDC and ORR have promulgated guidelines for both overseas and domestic health assessments in order "to promote and improve the health of…refugees… and prevent the importation of infectious diseases and other conditions of public health significance into the U.S.", as well as to help create the conditions for refugees' self-sufficiency (CDC, About Refugees). Overseas medical documents are brought with the refugee to the U.S., and RRA staff and RIHP staff have access to these documents.

Many refugees have spent years, sometimes even decades, in refugee camps in host countries before finally arriving in the U.S. Their experiences of displacement due to war, trauma, disease or famine, create challenges for health care provision and other aspects of readjustment and resettlement in the U.S. It is therefore crucial to conduct thorough domestic medical examinations.

Generally, the domestic RHA should be initiated within 30 days of arrival, and should be completed within 90 days of U.S. arrival. The Connecticut RIHP guides the initiation of RHAs, and collects, analyzes, and reports RHA data to federal, state and local agencies. The RIHP works with RRAs, medical care providers, and local health departments to ensure the timely assessment of refugees' health, and follow-up as necessary.

SECTION II: COMPONENTS OF THE DOMESTIC REFUGEE HEALTH ASSESSMENT

The domestic RHA is not the same as a physical exam for the U.S.-born general population. The RHA incorporates many screenings and tests for diseases not usually seen in the U.S.-born population (e.g., parasites, tuberculosis, hepatitis B, elevated blood lead level). In addition, refugees may not have had easy or consistent access to dental health, mental health, and other specialized medical services before U.S. arrival.

The CDC has issued a set of revised RHA guidelines and has created a checklist for quick reference (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html). In July 2012, ORR issued *State Letter 12-09: Revised Medical Screening Guidelines for Newly Arriving Refugees* and a companion checklist which outline the main components of RHAs (http://www.acf.hhs.gov/sites/default/files/orr/state_letter_12_09_revised_medical_screening_guidelines_for_newly.pdf). These federal documents provide the foundation for Connecticut's RHA procedures and reporting.

In general, the Connecticut domestic RHA should include the items listed below, as described by CDC and ORR guidelines:

- Medical history (includes review of overseas records)
- Physical examination & review of systems (includes: mental health, dental, hearing, vision screenings, nutritional and reproductive assessments, health education and guidance)
- Lab tests (e.g., complete blood count with differential; serum chemistries, urinalysis, cholesterol testing, pregnancy, HIV, hepatitis B & C, blood lead level, syphilis, chlamydia, newborn screening tests)
- Preventive health and other screening activities (includes: immunization review and catch-up; tuberculosis screening, stool ova and parasite testing, strongyloidiasis serology or presumptive treatment, schistosomiasis serology or presumptive treatment, malaria testing, vitamin level testing)

A Note on Overseas Medical Documentation:
It is recommended that RRA staff ensure that all refugees show the medical provider any available overseas medical documentation completed before U.S. entry (e.g., chest X-ray, immunization paperwork, etc.) so that providers may perform a review of these documents. If medical documentation is unavailable from the refugee's entry packet, and the RRA is unable to obtain information from other means, the DPH RIHP may be able to access those documents through the CDC's Electronic Disease Notification System (EDN), if necessary.

A Note about Immunizations: RHA forms should show evidence of an evaluation of any immunizations given overseas and should show documentation of immunizations given during the domestic RHA. However, RHAs are not the same as the medical examination required for adjustment of immigration status to permanent resident, which must be certified by a Civil Surgeon. Therefore, ***while a partial record of vaccines may be entered on the RHA form, it should not be used as the complete or sole proof of a refugee's full immunization for purposes of status adjustment.***

A Note about Interpretation: The provision of RHAs should comply with the 2001 National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards) promulgated by the U.S. Department of Health and Human Services Office of Minority Health. CLAS standards #4-7 refer to the use of competent language assistance and are based on Title VI of the Civil Rights Act of 1964. The CLAS Final Report notes that "Title VI requires all entities receiving federal financial assistance, including health care organizations, take steps to ensure that [limited English proficiency] persons have meaningful access to the health services that they provide" (DHHS, CLAS Standards 2001). The text of CLAS standards #4-7 are provided in Section IV of this document.

SECTION III: GUIDELINES FOR COMPLETION AND DISTRIBUTION OF REFUGEE HEALTH ASSESSMENT FORM

A: REFUGEE DEMOGRAPHIC INFORMATION

In preparation for the domestic RHA, RRA staff often assist refugees to complete the demographics part of the RHA form, as described below.

Table 1. Refugee Demographic Information

ITEM	DEFINITION	HOW TO FILL OUT THIS FIELD
Alien #:	Unique, 9-digit, identification number assigned overseas to U.S. entrants. (Asylees and other entrants may have "Alien numbers" ("A#") assigned when they are granted asylum). This number may be found on overseas medical examination records, and sometimes on visas or other official U.S. documentation.	XXX-XXX-XXX
Date of Health Assessment	Date the ***majority of the initial health assessment was performed***. This is ***not*** the date when blood work or laboratory tests were initiated, or when a PPD was first placed.	MM/DD/YYYY
Patient Name: LAST, FIRST, MIDDLE	This may be found on overseas medical examination records, and on visas or other official U.S. documentation. Please check overseas documentation for correct name order.	LAST, FIRST, MIDDLE
Sex:	Male or female. This may be found on overseas medical examination records, and sometimes on visas or other official U.S. documentation. Connecticut does not yet have an "Other" sex category.	Check M or F
Date of Birth	This may be found on overseas medical examination records, and sometimes on visas or other official U.S. documentation.	MM/DD/YYYY
Street Address, City, State, Zip:	Current address in the U.S. This may either be the address of initial resettlement, or the RRA/sponsor's address.	Fill out with currently known address, or RRA address if necessary.
Home Telephone #:	Current telephone number in the U.S. This may either be the phone number of initial resettlement, or the RRA/sponsor's phone number.	Fill out with currently known phone #, or RRA phone # if necessary.
Race:	The U.S. Census requires that data be collected about people's race as defined in the federal Office of Management and Budget (OMB) *Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* of 1997 (OMB 2012, http://www.whitehouse.gov/omb/fedreg_1997standards). This data may not be found on overseas documentation.	Fill out according to self-report of refugee. If they do not know or understand the racial categories, you might try asking them, "Americans categorize certain physical characteristics according to 'racial groups.' In the U.S., someone might consider you to be of 'Asian race', since you are from [Bhutan/ Thailand/ India/ Nepal]. Would it be acceptable to you to classify you in this way?" Mark down what they say.

Ethnicity	The U.S. Census requires that data be collected about people's ethnicity (defined solely as whether or not a person is "Hispanic or Latino") as defined in the OMB's 1997 *Statistical Policy Directive No. 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting* (OMB 2012, http://www.whitehouse.gov/omb/fedreg_1997standards). This data may not be found on overseas documentation.	Fill out according to self-report of refugee. If they do not know or understand the racial categories, you might try asking them, "Americans categorize certain physical and linguistic characteristics according to 'ethnic groups.' In the U.S., someone might consider you to be of 'Hispanic or Latino descent', since you are from [Cuba/ Peru/ Philippines]. Would it be acceptable to you to classify you in this way?" Mark down what they say.
Country of Birth	Country of birth, rather than country of citizenship or last residence, is important for public health purposes. This may be found on overseas medical examination records, and sometimes on visas or other official U.S. documentation.	Country of birth. Check against overseas records.
U.S. Entry date:	This is the official U.S. Quarantine Station date, or other official U.S. entry date, not the date that a RRA or provider was notified of U.S. entry. This may be found on overseas medical examination records, and sometimes on visas or other official U.S. documentation.	MM/DD/YYYY
Language needs: Preferred language, language used for interpretation	This may be found on overseas medical examination records. Determine if an interpreter is needed or not. Please ask the refugee what language they prefer to receive health information in. If an interpreter was used, indicate that fact, and which language was used.	1. Interpretation needed: Check yes or no. 2. Enter language preferred for health information. 3. If an interpreter was used, enter which language was used.
Overseas Class A, B1, B2 Status:	This classification indicates that overseas physicians have noted possible infection or exposure to certain diseases. The most common overseas classification will be "B1 (or B2) Tuberculosis". These persons should be evaluated as soon as possible to rule out or treat active TB disease, or latent TB infection (LTBI). This classification may be found on overseas medical examination records.	Mark down "B1", "B2", "B3", or "A" classification for TB or other diseases - only if shown on the overseas documents.

B: SCREENING/TEST RESULTS

The purpose of a domestic refugee health assessment is to screen for communicable diseases of public health importance, to review overseas medical documentation for potential health issues, and to diagnose and treat those and other health concerns so that refugees may more easily resettle in the U.S.

While full clinical information will generally remain in patients' medical records at their primary care provider's institution, the RHA form reflects the public health mission of the federal CDC and ORR refugee and immigrant

health programs. Table 2 describes how to fill out the RHA form for each screening requested, in the order they appear on the form.

Table 2. Screenings and Test Results for RHA

ITEM	DEFINITION	HOW TO FILL OUT THIS FIELD
Immunizations	Immunization records from overseas medical examinations should be found in overseas documentation. However, CDC notes that, "Refugees, unlike most immigrant populations, are not required to have any vaccinations before arrival in the United States… Therefore, most refugees, including adults, will not have had complete Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations when they arrive in the United States." See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/immunizations-guidelines.html)	Review overseas records, test for immunity if appropriate. Enter dates and types of vaccinations given or referrals as appropriate. Note if begun on immunization catch-up schedule.
Tuberculosis Screening **(TB screening must be done for all refugees 6 months or older, *regardless of BCG history.*)**	While TB screening has usually been done during the refugees' overseas examinations, often there is a time lag of several months between those tests and U.S. entry. In addition, it is sometimes the case that refugees are unable to have the TB screenings overseas. For this reason, domestic **TB screening must be done for all refugees aged 6 months or older.** -Evaluate overseas records. -Evaluate for signs or symptoms of disease during the physical examination. - ***Regardless of BCG history,*** administer a Mantoux tuberculin skin test for patients > 6 months of age or age-appropriate (not for <5 years old) interferon-gamma release assay (IGRA). -**Chest X-ray MUST be done if:** Positive TST (>10mm induration) or positive blood assay results, **OR** TB Class A or B designation from overseas exam, **OR** if symptomatic, regardless of TST or IGRA results. Exceptions to TST screening at domestic RHA: -Do not repeat TST if a *documented* previous positive TST result is available. -If the refugee reports a history of a previous severe reaction to a TST (e.g. blistering, ulceration), repeating the TST is contraindicated. See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html)	Screen and record date and type of test, and record test results.
Tuberculosis Diagnosis **(MUST CHECK ONE)**	See above, and see the CDC guidelines for more information (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/tuberculosis-guidelines.html)	Record diagnosis as appropriate. Record treatment information as known.

Hepatitis B Screening	**All refugees originating from countries where hepatitis is intermediately or highly endemic** (hepatitis B virus surface antigen prevalence >2%), **as well as those who are at risk for hepatitis B infection should be tested for hepatitis B virus infection and existing immunity.** Evidence of immunizations should be on the overseas medical documents. ***Draw blood first, then vaccinate, in order to avoid false positive results.*** -Positive anti-HBs and /or anti-HBc indicates immunity; no HBV vaccine needed. -Positive HBsAg indicates patient is infectious. -Refer persons with chronic HBV infection for additional ongoing medical evaluation. Vaccinate previously unvaccinated and susceptible children and adults. Refugees who are not immune and not chronically infected should be offered vaccination. See the CDC guidelines for more information: (www.cdc.gov/hepatitis/HBV/HBVFaq.htm), (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/viral-hepatitis.html)	Enter screening results and referrals as appropriate. If hepatitis B screening not done, indicate reason why.
Hepatitis C Screening	Screen ONLY refugees in high-risk groups: (e.g., IDUs, HIV+; body piercings/tattoos, etc.). See the CDC guidelines for more information (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/viral-hepatitis.html)	Enter screening results and referrals as appropriate.
HIV	Since January 4, 2010, refugees and immigrants are no longer tested overseas for HIV before U.S. entry. Therefore, the CDC recommends domestic HIV "[s]creening of all refugees 13-64 years of age…[and]… screening of all refugees on arrival, including those ≤12 years and ≥64 years of age, is also encouraged." See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/screening-hiv-infection-domestic.html)	Enter screening results and referrals as appropriate.
Syphilis	Note: although most refugees have been screened overseas for syphilis, **refugees ≥ 15 years old must also be screened domestically for syphilis, *regardless of overseas documentation.*** -VDRL/RPR test: If positive, conduct confirmatory test, then treat or refer as appropriate; OR -EIA test: IF positive, conduct confirmatory test, then treat or refer as appropriate See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html)	Screen and enter results, follow-up and/or treatment.
Chlamydia	Testing for women up to 26 years old; or older with risk factors. See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html)	Enter screening results and referrals as appropriate.
Gonorrhea	Testing only for specific groups: See the CDC guidelines for more information:	Enter screening results and

	(http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/sexually-transmitted-diseases.html)	referrals as appropriate.
Laboratory Tests	Urinalysis, serum chemistry and cholesterol testing as per CDC and ORR guidelines. See CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html)	Test and record results as appropriate.
Lead Screening **(For all refugee children 6 mos. to 17 years old)**	Refugee children are at risk for elevated blood lead levels due to the circumstances surrounding their relocation, and they are not tested for lead before U.S. arrival. The CDC notes that, "… potential lead exposures include lead-containing gasoline combustion, industrial emissions, ammunition manufacturing and use, burning of fossil fuels and waste, and lead-containing traditional remedies, foods, ceramics, and utensils." **All refugee children aged 6 months up to 17 years old, should be screened for blood lead levels.** See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html)	Enter screening results and referrals as appropriate. If lead screening not done, indicate reason why.
CBC with Differential	A complete blood count with differential should be done for all refugees as part of the RHA. The RHA form requests results for eosinophilia as potentially indicative of parasite infection. See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/general-guidelines.html#blood; http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html)	Record results as appropriate. If eosinophilia assessment not done, indicate reason why.
Intestinal Parasites Screening	Many refugees resettle in the U.S. from areas of the world where intestinal parasites are endemic. Many refugees may have been treated at the pre-departure medical examination with an antihelminthic drug. If given, treatment should be indicated on the refugees' overseas medical documents. According to the CDC: ***"1. Screening for parasitic infection in asymptomatic refugees who had no pre-departure treatment:*** A refugee who received no overseas predeparture antiparasitic treatment should receive post-arrival intestinal parasite screening tests. This evaluation should include O&P examinations performed on separate morning stools by the concentration method. All potentially pathogenic parasites detected should be treated. In addition, serological studies should be performed for strongyloides (all refugees) and for schistosomiasis (sub-Saharan African refugees). An eosinophil count should be routinely performed as part of the domestic medical screening examination. ***2. Screening for parasitic infection in asymptomatic refugees who received single dose pre-departure albendazole +/- pre-departure praziquantel:*** These persons should have an absolute eosinophil count as part of their	Review overseas records for pre-departure presumptive treatment and enter results. Enter presumptive treatment or serology or stool specimens, as appropriate. Refer as appropriate.

	hematologic profile during domestic routine screening and serological testing for strongyloides and schistosomiasis in sub-Saharan African refugees (if not previously treated with praziquantel). ***3. Screening for parasitic infection in asymptomatic refugees who received high-dose pre-departure albendazole (7 days) OR ivermectin +/- praziquantel:*** These persons should have an absolute eosinophil count as part of their routine domestic hematologic profile." See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/intestinal-parasites-domestic.html)	
Malaria Screening	Many refugees resettle in the U.S. from areas of the world where malaria is endemic. See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/malaria-guidelines-domestic.html)	Enter screening results and referrals as appropriate.
Mental Health Screening	Many refugees have suffered trauma, torture, and social and physical dislocation during their flight and resettlement. In addition, mental health issues may manifest as pain or other somatic complaints. See the CDC guidelines for more information: (http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html)	Review overseas documents for mental health issues. Perform mental health screening, and enter results and referrals as necessary.
Other Screenings Conducted	***These screenings should be conducted for all refugees.*** These include: dental, hearing, vision, nutrition/vitamin levels, and pregnancy. Please indicate if screened, treated, and/or referred.	Enter screening results and referrals as appropriate.
Other Referrals	Please indicate any referrals made. The most common include: primary care, infectious diseases; HIV/STI/STD, women's health, prenatal health, newborn screening, nutrition/vitamins, hypertension, diabetes, health education, parasitology, pain. Space is provided for other referrals made.	Enter as appropriate.
Comments	Further concerns or actions taken for RHA.	Please fill in as necessary.

C: PROVIDER INFORMATION

Table 3. RHA Provider Information

Physician Name	Name of provider who conducted the initial health assessment.	LAST, FIRST, MIDDLE
Facility Name	Name of provider's practice or health care facility.	Write clearly, or a stamp may be used.
Facility Address	Street address of provider's practice or health care facility.	Write clearly, or a stamp may be used.

Facility Phone #	Phone number of provider's practice or health care facility.	Write clearly, or a stamp may be used.
Fax #	Fax number of provider's practice or health care facility.	Write clearly, or a stamp may be used.
Person Completing Report	In many cases, this may be the same as the physician name.	Write clearly, or a stamp may be used.
Date of Report	Date that the form was filled out. This may also be the date of RHA.	MM/DD/YYYY

D. DISTRIBUTING COPIES OF THE RHA FORM; FOLLOW-UP INFORMATION REQUESTS

NEW FOR THIS FORM:
This form is available in pdf format, and is posted on the RIHP website (http://www.ct.gov/dph/refugeehealth). The form is no longer printed in multiple, multi-colored pages as before. ***It is therefore the responsibility of both RRA staff and providers to ensure that they retain sufficient copies for use in medical and client files.***

PLEASE REVIEW THE FORMS BEFORE SENDING TO DPH:
Usually, designated RRA staff ensure that the RHA form is returned to DPH. In this case, RRA case managers will review the form to be sure that the RHA data screening information has been filled out by the provider. After this review, the RRA staff will send the form to DPH. This may be done by U.S. mail, by confidential fax, or by high-quality scanning and electronic mail using state's Tumbleweed secured e-mail system (which must be set up with the RIHP).

Occasionally, providers will send in the RHA Form to the RIHP. In this case, providers should ensure that all dates and tests, results, diagnoses, and/or treatments are properly entered onto the form before sending to the RIHP. Usually, providers opt to send these forms by U.S. mail.

FOLLOW-UP INFORMATION REQUESTS: The RIHP may contact RRA staff and/or medical providers for certain follow-up information as necessary.

IN SUM:

1. RRA staff and providers should **review information** recorded on the form.
2. Submit the **original** form to the DPH RIHP (legible scanned and faxed documents are acceptable).
3. A **copy should be given to the refugee** and/or kept in the refugee's health files at the resettlement agency in a secured location. This is the refugee's proof of initial health assessment.
4. **A copy should be retained by the medical provider**.

QUESTIONS OR CONCERNS? At any time, if there are questions, requests, or concerns about the RHA or other guidelines, please do not hesitate to contact the RIHP Coordinator (see Section IV below). The RIHP will work with all parties involved in the RHA process to ensure efficient, accurate, and timely data collection.

SECTION IV: ACKNOWLEDGEMENTS; CONTACT INFORMATION; CLAS STANDARDS #4-7; REFERENCES CITED

ACKNOWLEDGEMENTS

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CONTACT INFORMATION

If you have any questions about filling out the RHA Form, please contact Alison Stratton, Refugee and Immigrant Health Coordinator, at (860) 509-7722, or e-mail alison.stratton@ct.gov.

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CLAS STANDARDS # 4-7:

National Standards for Culturally and Linguistically Appropriate Services in Health Care promulgated by the U.S. Department of Health and Human Services Office of Minority Health. (2001)

- **Standard 4.** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- **Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- **Standard 6.** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- **Standard 7.** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

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