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Medicare Health Assessment for Refugees and other Humanitarian Entrants

Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed below.

Patient's Name ……..……..……

Mother/Father/Guardian (For children)
……

Proposer (if applicable)……..

Current contact details

Address
……
……
Phone ……..……
Email ……..

Male ☐ Female ☐ DOB …../…../….. or Age …...

Nationality ……

English Skills Needs interpreter Yes ☐ No ☐
Interpreter name/s …….
Language/s spoken (in order of preference)
……
……

The Doctors' Priority Line 1300 131 450 provides priority access to fee-free telephone interpreting services for doctors

Patient Consent

Explanation of health assessment given Yes ☐

Patient consent for health assessment given Yes ☐
Date consent was given: __/__/____

Consent given for information to be collected by:

Health Worker ☐

Practice Nurse ☐

Other ☐ please specify
……

Proof provided of eligible visa status (*see list below*)

Eligible Visa Categories:

☐ 200 Refugee
☐ 201 In-country Special Humanitarian
☐ 202 Global Special Humanitarian
☐ 203 Emergency Rescue
☐ 204 Woman at Risk
☐ 070 Bridging (Removal Pending)
☐ 695 Return Pending
☐ 866 Protection
☐ 786 Temporary (Humanitarian Concern)

Migration History

Country of Birth …….. Ethnicity (if different)
……

Countries/places of transit
Country: Dates:
Country: Dates:
Country: Dates:

☐ Refugee Camp/s ☐ Detention Centre/s
Arrival date in Australia: …….. (provide proof)

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HEALTH ASSESSMENT SUMMARY

The health assessment should be undertaken in a culturally sensitive manner that is appropriate to the needs of the patient

PATIENT'S OVERALL HEALTH STATUS

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HEALTH ISSUES IDENTIFIED AND DISCUSSED WITH PATIENT

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TESTS UNDERTAKEN AS CLINICALLY INDICATED, RESULTS AND WHAT THEY MEAN

TEST	RESULTS AND WHAT THEY MEAN

RECOMMENDED INTERVENTION ……

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MEDICAL HISTORY

Patient history

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Pre-departure Medical Screening

Ask for the patient's health manifest if available. This contains information about pre-migration health screening/treatment and health undertaking.

Pre-migration health screening ☐ Yes ☐ No ☐ Unknown

Pre-migration health treatment ☐ Yes ☐ No ☐ Unknown
If yes, note health treatment:……

Health undertaking ☐ Yes ☐ No ☐ Unknown
If yes, note follow-up:……

Date of Health undertaking (if known):…… Service provided by Dr:……

CURRENT HEALTH ISSUES	CURRENT RISK FACTORS

Family history of chronic disease

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……
……
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Other relevant family history

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……
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……
……

Chronic conditions

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……

Allergies/Drug Intolerance

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Current medications

(including prescription and over the counter and supplied by doctor without prescription)

……
……
……
……
……

Nutritional assessment

(consider malnutrition, vitamin deficiency or anaemia)

……
……
……
……
……

Immunisation status (referring to current age/sex schedule)

- For children consider full course and include on the Australian Child Immunisation Register
- For teenagers consider measles, mumps and rubella vaccine, Hepatitis B, Meningococcal C
- For adults consider serology and booster.

TYPE	DATE	TYPE	DATE

PSYCHOLOGICAL HISTORY

Trauma history (history of incarceration, family separation, torture)

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……
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……

Mood (consider depression, post traumatic stress disorder, survivor guilt)

IDENTIFIED ISSUES	ACTION

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PHYSICAL EXAMINATION

Temperature:..... Weight:…..… Height:..…… BMI:..…… Percentile Chart for children:.....

IDENTIFIED ISSUES	ACTION

Cardiac Examination **Blood pressure: …… Pulse rate and rhythm: Normal ☐ Abnormal ☐**

IDENTIFIED ISSUES	ACTION

Respiratory and abdominal examination

IDENTIFIED ISSUES	ACTION

Gums and dentition (consider caries, gum disease and decreased dentition)

IDENTIFIED ISSUES	ACTION

Ear and hearing

IDENTIFIED ISSUES	ACTION

Visual acuity

IDENTIFIED ISSUES	ACTION

Other injuries or scars

IDENTIFIED ISSUES	ACTION

INVESTIGATIONS IF CLINICALLY INDICATED

Investigation	Tests Done	Tests Ordered	Arrangements (e.g. referrals)
Iron deficiency	☐	Date: . . . / .. . . /. . . .	
Lipids	☐	Date: . . . / .. . . /. . . .	
Glucose	☐	Date: . . . / .. . . /. . . .	
Hepatitis/Rubella serology	☐	Date: . . . / .. . . /. . . .	
Urine (Urinary tract infection, Chlamydia with pregnancy)	☐	Date: . . . / .. . . /. . . .	
Faecal examination for parasites	☐	Date: . . . / .. . . /. . . .	
Serum Vitamin D	☐	Date: . . . / .. . . /. . . .	
HIV	☐	Date: . . . / .. . . /. . . .	
Chest X ray	☐	Date: . . . / .. . . /. . . .	
Mantoux skin test for Tuberculosis	☐	Date: . . . / .. . . /. . . .	
Other:			

Advice and Information to the Patient

Health Issues identified and discussed with patient

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Recommendations and advice given to the patient

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Referrals

☐ Surgical	……	☐ Maternal/Child health	……
☐ Dental	……	☐ Obstetrics	……
☐ Optometry	……	☐ Gynaecology	……
☐ Audiometry	……	☐ Allied Health	……
☐ Mental Health	……	☐ Other	……

Next appointment with doctor:	Date: …../…../…..	
GP: Dr. ……	GP's signature ……	Date: …../…../…..