



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. The first page of this form can be used as a report of the health assessment.

Patient's Name

Mother/Father/Guardian (For children)
.....

Proposer (if applicable)

Current contact details

Address

Phone

Email

Patient Consent

Explanation of health assessment given Yes

Patient consent for health assessment given Yes

Date consent was given: _ / _ / ____

Male Female DOB _ / _ / ____ or Age ____

Nationality

English Skills Needs interpreter Yes No

Interpreter name/s

Language/s spoken (in order of preference)
.....
.....

The Doctor's Priority Line 1300 131 450 provides priority access to fee-free telephone interpreting services for doctors in private hospitals.

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) visa
- 695 (Return Pending) visa
- 866 (Protection) visa
- 786 (Temporary (Humanitarian Concern)) visa

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)



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

.....

HEALTH ISSUES IDENTIFIED AND DISCUSSED WITH PATIENT

.....

TESTS UNDERTAKEN AS CLINCIALLY INDICATED, RESULTS AND WHAT THEY MEAN

TEST	RESULTS AND WHAT THEY MEAN

RECOMMENDED INTERVENTION

.....

Next appointment with doctor:

Date __ / __ / ____

GP: Dr

GP's signature

Date __ / __ / ____



MEDICAL HISTORY

Patient history

.....

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

.....

Other relevant family history

.....

Chronic conditions

.....



Allergies / Drug Intolerance

.....

.....

.....

.....

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)

.....

.....

.....

Mood

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

IDENTIFIED ISSUES	ACTION



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	<input type="checkbox"/>	Date __/__/__	
Lipids	<input type="checkbox"/>	Date __/__/__	
Glucose	<input type="checkbox"/>	Date __/__/__	
Hepatitis/Rubella serology	<input type="checkbox"/>	Date __/__/__	
Urine (Urinary tract infection, Chlamydia with pregnancy)	<input type="checkbox"/>	Date __/__/__	
Faecal examination for parasites	<input type="checkbox"/>	Date __/__/__	
Serum Vitamin D	<input type="checkbox"/>	Date __/__/__	
HIV	<input type="checkbox"/>	Date __/__/__	
Chest X ray	<input type="checkbox"/>	Date __/__/__	
Mantoux skin test for Tuberculosis	<input type="checkbox"/>	Date __/__/__	
Other			

Advice and Information to the Patient

Health issues identified and discussed with patient

.....

Recommendations and advice given to the patient

.....

Referrals

- | | |
|--|--|
| <input type="checkbox"/> Surgical | <input type="checkbox"/> Maternal/Child health |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Optometry | <input type="checkbox"/> Gynaecology |
| <input type="checkbox"/> Audiometry | <input type="checkbox"/> Allied Health |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Other |