
SUMMARY CHECKLIST FOR THE DOMESTIC MEDICAL EXAMINATION FOR NEWLY ARRIVING REFUGEES

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**Summary Checklist for the
Domestic Medical Examination for Newly Arriving Refugees**
For use when screening asymptomatic refugees arriving in the United States

This document presents a summary checklist for the testing suggested in the 13 sections of the [Domestic Medical Examination for Newly Arriving Refugees](#). The steps outlined here do not represent mandatory screening requirements, but are intended as a guide to assist clinicians in performing a comprehensive medical evaluation. This summary checklist is for use when screening asymptomatic refugees. Refugees with clinical complaints should receive diagnostic testing guided by their signs and symptoms.

Checklist

Items marked with a check box () indicate “action item” components of the medical examination. Links are provided to the full guidelines for additional details.

Medical screening should be conducted as soon as possible, and refugees should be assured ongoing primary care.

General medical examination

[History and physical examination](#)

○ [Nutrition and growth](#)

- Take dietary history (e.g., restrictions, cultural dietary norms, food allergies).
- Collect anthropometric indices, including weight, height, and, for young children, head circumference.

○ Pregnancy test

- Perform when clinically indicated prior to administration of any vaccines or medications which may present a risk.
- Recommend prenatal vitamins and referral for services if test is positive.

○ [Immunizations](#)

- Record previous vaccines, lab evidence of immunity, or history of disease.
- Give age-appropriate vaccines as indicated. Complete any series that has been initiated. (Do not restart a vaccine series.)
 - Doses are valid if given according to accepted [ACIP](#) or state schedules.
 - If patient has no documentation, assume he or she is not vaccinated.
 - Laboratory evidence of immunity is an acceptable alternative, as determined by the provider.

Mental health screening

[Mental health screening](#) is encouraged, depending on available services.

General laboratory testing

- [General laboratory testing](#) is recommended for all refugees.
 - Recommendations for all refugees
 - Perform complete blood count with differential and platelets.
 - Conduct [urinalysis](#) (optional in persons unable to provide a clean-catch specimen).
 - Consider testing glucose and serum chemistries.
 - Recommendations for infants
 - Conduct infant metabolic screening for newborns, according to state guidelines.

Disease-specific laboratory testing

- [Tuberculosis](#)
 - Review overseas records.
 - Evaluate for signs or symptoms of disease, history of contacts, and physical examination (low threshold for evaluation).
 - Conduct a Tuberculin Skin Test or IGRA. (Use of IGRA in children < 5 years of age is not encouraged.)
 - For a positive screening test, perform chest x-ray and sputum testing as indicated.
- [Lead testing](#)
 - Screen all refugee children 6 months to 16 years of age.
 - Conduct an additional lead test on all children aged 6 months - 6 years within 3-6 months of placement in a permanent residence, regardless of the results of the initial lead test.
- [Malaria](#)

Note: All sub-Saharan **African** (SSA) refugees who arrived from **countries that are endemic for *Plasmodium falciparum*** and who do not have a contraindication should be assumed to have received [pre-departure presumptive antimalarial therapy](#) with artesunate-combination therapy (ACT).

 - Refugees who require [post-arrival testing or presumptive treatment](#) include the following: (The most sensitive test for persons with sub-clinical malaria is polymerase chain reaction (PCR); when PCR is not available, traditional blood films and/or a rapid antigen test may be used but have limited sensitivity in asymptomatic persons.)
 - SSA refugees receiving no presumptive treatment prior to departure. This includes any pregnant or lactating women, or children weighing less than 5 kg at the time of departure, for whom presumptive treatment was contraindicated.
 - Any refugee from a [malaria-endemic country](#) with signs or symptoms of infection should receive a thorough evaluation.
 - Refugees **not** requiring post-arrival testing or presumptive treatment include the following:
 - SSA refugees receiving presumptive treatment prior to departure.
 - All refugees from malaria-endemic countries outside SSA.

○ [Intestinal and Tissue Invasive Parasites \(ITIP\)](#)

Notes:

- Post-arrival screening for invasive parasites (IP) will depend on the [region of departure and pre-departure presumptive therapy received](#).
- Currently, all refugees without contraindications from the Middle East, South and Southeast Asia, and Africa receive a single dose of albendazole prior to departure. In addition, all SSA refugees without contraindications receive treatment with praziquantel for schistosomiasis. The only population currently receiving presumptive therapy for strongyloides is Burmese refugees, who receive ivermectin if they do not have contraindications.

For those who have contraindications or who did not receive complete pre-departure therapy, the following ITIP screening is recommended:

- [For refugees who had no pre-departure presumptive treatment \(Figure 1\)](#):
 - Roundworms/nematodes (all refugees): Conduct stool ova and parasites examination (2 or more samples) or provide presumptive treatment.
 - *Strongyloides* (all refugees): Provide presumptive therapy or conduct diagnostics for *Strongyloides* (e.g., serologies for strongyloides, 2 or more stool ova and parasites examinations, and/or *Strongyloides* culture/agar method).
 - Schistosomiasis (SSA refugees): Provide presumptive therapy or conduct serologies for schistosomiasis (for SSA refugees who did not receive praziquantel).
 - Absolute eosinophil count (routinely recommended as part of the hematology testing and is not sensitive or specific for invasive parasites; however, a persistently elevated count indicates the need for further investigation).
- [For refugees who received incomplete presumptive treatment \(Figure 2\)](#):
 - *Strongyloides* (all refugees): Provide presumptive therapy or conduct diagnostics for *Strongyloides* (e.g., serologies for strongyloides, 2 or more stool ova and parasites examinations, and/or *Strongyloides* culture/agar method).
 - Schistosomiasis: Provide presumptive therapy or conduct serologies for schistosomiasis (SSA refugees who did not receive praziquantel).
 - Absolute eosinophil count (routinely recommended as part of the hematology testing and is not sensitive or specific for invasive parasites; however, a persistently elevated count indicates the need for further investigation).
- For refugees who received complete pre-departure presumptive treatment:
 - Absolute eosinophil count (routinely recommended as part of the hematology testing and is not sensitive or specific for invasive parasites; however, a persistently elevated count indicates the need for further investigation) ([Figure 3](#)).

○ [Sexually transmitted diseases](#)

Obtain history for signs and symptoms and conduct physical examination.

- Syphilis
 - If no documentation, obtain VDRL (venereal disease research laboratory) or RPR (rapid plasma regain) for the following:
 - All refugees \geq 15 years old
 - Refugees $<$ 15 years old if
 - ❖ sexually active or history of sexual abuse
 - ❖ mother who tests or tested positive

- ❖ exposure in a [country endemic for other treponemal subspecies](#) (e.g., yaws, bejal, pinta).
 - Conduct confirmation testing for positive treponemal tests.
- Chlamydia
 - Conduct a urine nucleic amplification test for the following:
 - Women < 25 years old who are sexually active
 - Women > 25 years old with risk factors (e.g., new or multiple partners)
 - Leucoesterase (LE) positive on urine sample
 - Women or children with history of or at risk for sexual assault
 - Any refugee with symptoms
- Gonorrhea
 - Conduct a urine nucleic amplification test for the following:
 - Leucoesterase (LE) positive on urine sample
 - Women or children with history of or at risk for sexual assault
 - Any refugee with symptoms
- [HIV](#)

As of January 4, 2010, refugees are no longer tested for HIV infection prior to arrival in the United States.

 - All refugees should be screened unless they opt out. Refugees should be clearly informed orally or in writing when/if they will be tested for HIV. A refugee's decision to decline an HIV test should be documented in the medical record.
 - [Screening](#) should be repeated 3-6 months following resettlement for refugees who had recent exposure or are at high risk.
 - Provide culturally sensitive and appropriate counseling for all HIV-infected refugees in their primary spoken language, and ensure the competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency.
 - Refer all refugees confirmed to be HIV-infected for care, treatment, and preventive services.
 - Special considerations for children:
 - Screen children ≤12 years of age unless the mother's HIV status can be confirmed as negative and the child is otherwise thought to be at low risk of infection (no history of high-risk exposures such as blood product transfusions, early sexual activity, or sexual abuse). In most situations, complete risk information will not be available; thus, most children ≤12 years of age should be screened.
 - For children <18 months of age, who test positive for HIV antibodies, test with DNA or RNA assays. Results of positive antibody tests in this age group can be unreliable because they may detect persistent maternal antibodies.
 - Provide chemoprophylactic trimethoprim/sulfamethoxazole for all children born to or breast-fed by an HIV-infected mother, beginning at 6 weeks of age and continuing until they are confirmed to be uninfected.

- Special considerations for pregnant women:
 - Screen all pregnant refugee women as part of their routine post arrival and prenatal medical screening and care.