	IOM • OIM	**Migration Health Assessment** ***WORKSHEET*** ***Form 04MH_A***	**1. Assessment Date:** **2. Program:** **3. Ref. ID No:**

4. Name :

(Last) *(First)* *(Middle)*

5. Gender: F ☐ M ☐	**6. DOB:**	**7. Principal Applicant: No ☐ Yes ☐**
8. Case No.	**9. Country: Syrian**	**10. Nationality: Syrian**
11. Exam Place: IOM Beirut	**12. Exam Country: Lebanon**	**13. Doctor:**

14. Health Assessment completed on:

15. Medical Conditions Identified

☐ None	☐ Syphilis	☐ Physical impairment/disability
☐ TB, active, infectious	☐ Other sexually transmitted diseases	☐ Significant Mental health condition
☐ TB, active, non-infectious	☐ Human immunodeficiency virus	☐ Addiction(abuse) of specific substances
☐ TB, inactive		☐ Other significant condition, specify:

16. Description of significant condition / Treatment / Recommendation	**ICD Code(s)**
	Update

17. TREATMENT Administered: No ☐ Yes ☐ *(pls. provide details in Remarks above, or attach the "IOM treatment form")*

☐ **Syphilis**		☐ **Anti-malaria**		☐ **De-worming**	
Dates:	**Drugs/Dosage:**	**Dates:**	**Drugs/Dosage:**	**Dates:**	**Drugs/Dosage:**
1. 2. 3.		1. 2. 3.		1. 2. 3.	

18. VACCINES Administered: No ☐ Yes ☐

Dates:	**Vaccine:**	**Dates:**	**Vaccine:**	**Dates:**	**Vaccine:**
1.		4.		7.	
2.		5.		8.	
3.		6.		9.	

19. Travel Recommendations	**20. Pregnancy**	**No ☐ Yes ☐**
Fit to travel: Yes ☐ Conditionally ☐ No ☐	a)To travel Before:	
Special attention on pre-flight assessment: No ☐ Yes ☐	b) Not to travel before:	
Hospitalization required: Pre-depart. ☐ Post-arrival ☐		

21. Equipment / Medication			**22. Escorts**	**No ☐ Yes ☐**
☐ Ambulance	☐ Stretcher	☐ Bowel Prep.	☐ Med. Escort-POE	☐ Family escort
☐ WCHR	☐ 3 seats	☐ Diapers	☐ Med. Escort-FD	☐ Operational Escort
☐ WCHS	☐ Oxygen	☐ Urinary catheter	*Medical Escort By:*	☐ Other, specify:
☐ WCHC	☐ Interflight Th admin.	☐ Other	☐ Doctor ☐ Nurse	

23. Post-travel recommendations	**23.A Follow-up needed :**	**No ☐ Yes ☐**
Special schooling/employment needs ☐	By whom:	Within:
Consequences on daily living activities (Assistance Required) ☐	☐ by GP	☐ one week
Special housing requirements ☐	☐ by Specialist, specify: Pediatric Neurosurgeon, Physical therapist	☐ one month
Excessive demands for the health service ☐		☐ 6 months

Remarks/Details:

Date: 29 Jan 2015	**Examining physician's name address and telephone number (stamp may be used):**

Signature:	Ramona El Haddad, +961 71300047

Form 04MH_B ***MEDICAL HISTORY&PHYSICAL EXAM***	**1. Assessment Date:**
	2. Program:

3. Name:	**4. Case No:** 245-13C01603	**5. Date of Birth:** ***03-Feb-82***

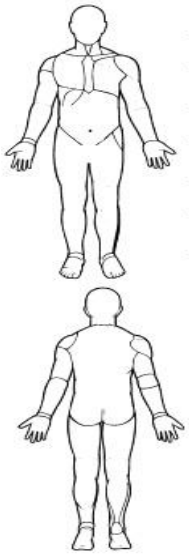
Yes No	**1. Medical History**		
☐ ☐	Illness or injury requiring hospitalization	☐ ☐	Recurrent fever (last 6 months)
☐ ☐	Surgical interventions	☐ ☐	Coughing
☐ ☐	Heart disease or high blood pressure	☐ ☐	Loss of weight (last 6 months)
☐ ☐	Neurologic disease, incl. stroke or seizures	☐ ☐	Sexually transmitted diseases
☐ ☐	Mental illness/problems	☐ ☐	Skin problems (rash, etc…)
☐ ☐	Stomach or bowel disease (incl. recent diarrhea)	☐ ☐	Tatoos, body piercing
☐ ☐	Liver or kidney disease	☐ ☐	History of blood transfusions
☐ ☐	Diabetes or other endocrine disorder	☐ ☐	History of torture/violence
☐ ☐	Urogenital problems / conditions	☐ ☐	Displaced from home, number of months:
☐ ☐	Hematologic disease	☐ ☐	Are you taking medications, specify below
☐ ☐	Muscle, bone and joint problems	☐ ☐	Do you have any drug allergies?
☐ ☐	Problems with eyes or ears	☐ ☐	Smoking habits: Years: No/day:
☐ ☐	Cancer or tumors	☐ ☐	Alcohol habits: Years: Units/week:
☐ ☐	TB, pneumonia, or other lung disease		
☐ ☐	Household member with significant. inf. disease (or TB contact in general)	☐ ☐	Illicit drug use? Specify past or present, name of the drug(s), quantity, period, when stopped (if in the past), any treatment

2. Reproductive history *Number*			
Pregnancies:		LM Period :	
Deliveries:		Are you pregnant?	☐ No ☐ Do not know ☐Yes
Babies born alive:		Gestation (what week?):	

3. Physical Examination:				(repeat if abnormal)			
Height		*cm*		*Vital sign*	*Initial*	*Repeated*	*Units*
Weight		*Kg*		BP			*mmHg*
BMI		*Kg/m²*		Pulse			*/min*
Head circumference (< 18months)		*cm*		Resp.rate			*/min*
Visual Acuity	***Uncorrected***			***Corrected***	***Correction (if available)***		
Left/ Right	/			/	/		

	N	***Abn***	***ND***		***N***	***Abn***	***ND***		***N***	***Abn***	***ND***
General appearance	☐	☐	☐	Endocrine	☐	☐	☐	Extremities	☐	☐	☐
Visible disabilities	☐	☐	☐	Respiratory	☐	☐	☐	Skin (incl. scars)	☐	☐	☐
Mental state	☐	☐	☐	Abdominal/GIT	☐	☐	☐	Neurologic	☐	☐	☐
EENT (incl. hearing)	☐	☐	☐	Musculo-skeletal	☐	☐	☐	Lymph nodes	☐	☐	☐
Teeth	☐	☐	☐	Genito-urinary	☐	☐	☐	Breasts	☐	☐	☐
Cardiovascular	☐	☐	☐	Hernial sites	☐	☐	☐	Pregnant: Yes ☐ No ☐ Fundal height (cm):			

Remarks/Notes:



IOM • OIM

Migration Health Assessment
CXR&TB LAB WORKSHEET
Form 04MH_CXR

1. Assessment Date:
2. Program:
3. Ref. ID No: Error! Reference source not found.

4. Name:

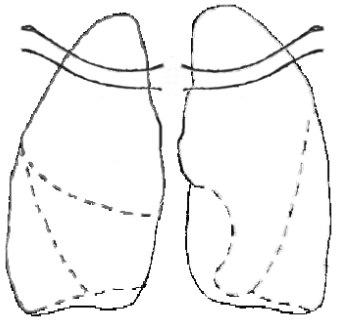
(Last) *(First)* *(Middle)*

5. Case NO: 245-13C01603	**6. Date of Birth:** ***03-Feb-82***

7. Chest X-Ray	☐ **Done on** ☐ **Normal** ☐ **Abnormal F/U needed** ☐ **Abnormal no F/U**
	☐ **Not Done due to:** ☐ **Age** ☐ **Pregnancy** ☐ **Other, Specify**
8. From the Medical file:	☐ **TB signs or symptoms** ☐ **Contact with TB patient** ☐ **History of TB**

9. Chest X-ray Interpretation by the Radiologist

☐ **Can suggest Active TB** (need smears)	☐ **Can suggest INACTIVE TB** (need smears if symptomatic)	☐ **Other X-ray findings**
☐ Infiltrate or consolidation	☐ Discrete fibrotic scar or linear opacity	☐ Musculoskeletal
☐ Any cavitary lesion	☐ Discrete nodule(s) without calcification	☐ Cardiac or major vessels
☐ Nodule with poorly-defined margins *(such as tuberculoma)*	☐ Discrete fibrotic scar with volume loss or retraction	☐ Pulmonary
☐ Linear, interstitial markings *(children only)*	☐ Discrete nodule(s) with volume loss or retraction	☐ Other
☐ Pleural effusion	☐ Upper lobe retraction or volume loss	
☐ Hilar/Mediastinal adenopathy	☐ Other (such as bronchiectasis)	
☐ Other (*such as miliary findings*)		



Date:	**Radiologist's Name:**	**Radiologist's Signature:**

10. IOM Physician's Comments on CXR

11. TB Smears and Cultures

Date:	**Smears** ☐ **Done** ☐ **Not Done**						**Cultures** ☐ **Done** ☐ **Not Done**				**DST** ☐ **Done** ☐ **Not Done**
	Neg	Scanty	AFB count	1+ (1-9 /10F)	2+ (1-10 /F)	3+ (>10/F)	Neg	Pos	Cont	Non Diagn.	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	
	☐	☐		☐	☐	☐	☐	☐	☐	☐	

12. TST	☐ **Done** ☐ **Not Done**		
Date taken	**Date read:**	**Result, mm:**	**History of BCG**

			No ☐ Yes ☐ Unknown ☐

Form 04MH_LAB ***LAB WORKSHEET***	**1. Assessment Date:**
	2. Program:

3. **Name**	**4. Case No** 245-13C01603	**5. Date of Birth:** ***03-Feb-82***

6. HIV Test ☐ **Done** ☐ **Not Done**				
Type:	**Date:**	**Test kit:**	**Test Results:**	**Test Notes:**
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Screening			☐ **Neg** ☐ **Pos** ☐ **Indt.**	
Confirmatory			☐ **Neg** ☐ **Pos** ☐ **Indt.**	

7. Syphilis Test ☐ **Done** ☐ **Not Done**					
Type:	**Date:**	**Test kit:**	**Test Results:**	**Titer:**	**Test Notes:**
Screening			☐ **Neg** ☐ **Pos**		
Confirmatory			☐ **Neg** ☐ **Pos**		

8. Urinalysis ☐ **Done** ☐ **Not Done**						**Microscopy:**
Date: **12-Dec-2007**	**Blood**	☐ **Neg** ☐ **Pos**	**Repeat Date:** **04-Dec-2007**	**Blood**	☐ **Neg** ☐ **Pos**	
	Albumin	☐ **Neg** ☐ **Pos**		**Albumin**	☐ **Neg** ☐ **Pos**	
	Sugar	☐ **Neg** ☐ **Pos**		**Sugar**	☐ **Neg** ☐ **Pos**	

9. CBC ☐ **Done on** ☐ **Not Done**							
Name:	**Result:**	**Unit**	**Ref. range:**	**Name:**	**Result:**	**Unit**	**Ref. range:**
WBC		x 10^3/mm^3	5.0-10.0	Eosinophils, %		Percent	0-4
RBC		x 10^6/mm^3	4.1-5.3	Basophils, %		Percent	0-2
Hemoglobin		g/dL	12.0-18.0	Neutrophils, abs		x 10^3/mm^3	1.8-7.8
Hematocrit		Percent	37.0-52.0	Lymphocytes, abs		x 10^3/mm^3	0.7-4.5
Platelets		x 10^3/mm^3	140-390	Monocytes, abs		x 10^3/mm^3	0.1-1.0
Neutrophils, %		Percent	45-76	Eosinophils, abs		x 10^3/mm^3	0.0-0.4
Lymphocytes, %		Percent	17-44	Basophils, abs		x 10^3/mm^3	0.0-0.2
Monocytes, %		Percent	3-10				

10. Other tests with Numeric Results					
Date:	**Test name:**	**Result:**	**Unit:**	**Ref. Range:**	**Test Notes:**
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				
	Select the test				

11. Other tests with Neg/Positive Results				
Date:	**Test name:**	**Test kit:**	**Test Results:**	**Test Notes:**
	Hep B		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	
	Select the test		☐ **Neg** ☐ **Pos**	

Lab Remarks: