Guidelines for Medical Examination of Newly Arriving Refugees

November 27, 2024

***Note**: For the purposes of this document, the term "refugee" includes, unless otherwise noted, all categories of individuals who are eligible for refugee benefits.*

According to the Office of Refugee Resettlement (ORR), the following populations are eligible for refugee programs and benefits: refugees, asylees, Cuban and Haitian entrants, Amerasians, Afghan and Iraqi Special Immigrants, and certain victims of severe forms of human trafficking.

Introduction

All newly arriving refugees are eligible for a medical examination. The timing of the examination is critical for successful resettlement. In accordance with federal guidelines, refugee health screening exams should be initiated within the first 30 days, but no later than on or after 90 days of entry into the U.S. Exams for asylees and victims of human trafficking should be initiated within the first 30 days, but no later than on or after 90 days of certification.

The purpose of the refugee health exam is to eliminate health-related barriers to successful resettlement and to protect public health in the U.S. by:

- Ensuring follow-up (evaluation, treatment and/or referral) of all Class A and Class B conditions identified during the Overseas Visa Medical Examination (OVME)
- Screening for a wide range of infectious diseases and non-communicable conditions
- Evaluating current health status and identifying health conditions that could impact long-term wellbeing
- Ensuring refugees are referred for follow-up to routine primary care and specialty care
- Initiating appropriate immunizations to facilitate school enrollment and adjustment of status from refugee to lawful permanent resident
- Providing health education to introduce a refugee to the U.S. health care system including primary care, insurance and other health issues such as nutrition and safety

In accordance with ORR State Letter #12-09, the medical examination activities outlined in this document represent a minimum standard of care for eligible refugees. Preventive health and extended screening services are available and should be utilized based on a refugee's risk factors or clinical indicators. Criteria for the core history and physical exam, laboratory testing and preventive health, and extended services are outlined in this document.

General Guidelines and Best Practices

1. These guidelines are for asymptomatic refugees. Refugees with signs or symptoms should receive diagnostic testing. A checklist of core activities is provided in the Refugee Medical Examination Protocol chart. Further detailed guidance is provided for each activity listed.

2. When a refugee does not speak English or has limited English proficiency, all services must be provided using trained multilingual and multicultural medical interpreters. In-person medical interpretation is preferred.
3. Refugee exams can be done by a licensed provider such as a nurse practitioner, physician assistant, public health or extended role nurse; however, a physician is preferred
4. Refugee health screening exams are to be initiated within the first 30 days, but no later than 90 days of entry into the U.S. Exams for asylees and victims of human trafficking should be initiated within the first 30 days, but no later than on or after 90 days of certification.
5. Health screening services must be coordinated with reception and placement services provided by a refugee's respective resettlement agency. Resettlement agencies are responsible for providing refugees with resettlement assistance upon their entry into the U.S. In part, this assistance includes coordinating initial health screenings, health care, and other referral services.
6. Clinic providers should reinforce cultural orientation messages during the screening where possible, including basic navigation of the health care system, the importance of routine and preventive care, the role of a primary care provider and the concept of a medical home.
7. To ensure continuity of health care, all refugees should be referred to a primary care provider. Referrals for other medical, dental, mental health, specialty care and other support services should be made as appropriate. Transportation is often a barrier to care; therefore, it is advisable that referrals are made within proximity to the refugee's residence, when possible. Counseling and coordination of care with other providers or agencies should be provided and consistent with the nature of the problem(s) and the refugee's and/or family's needs. When refugees are referred, the referral health care providers should receive the results of the initial health examination through established procedures for release of records.
8. Clinicians should employ a patient-centered approach and address social determinants of health.
9. For some refugees, the domestic medical examination may be the first full exam they have experienced; all steps should be clearly explained, and same-sex examiners provided if requested, when possible. It is advised to reassure refugees that this examination is for their health and not for regulatory purposes (prior to this, examinations have primarily been performed to identify conditions that may exclude the refugee from admittance - the domestic examination is primarily to benefit the refugees' health).
10. Consent and confidentiality may be novel concepts for refugees, particularly in the context of healthcare associated with the resettlement process. Consent, confidentiality and limits to confidentiality should be reviewed with refugee patients at the beginning of the first visit in the refugee's preferred language.
11. All information regarding activities performed and findings are to be recorded in the refugee's medical record. This includes all information from the following activities:
    - Medical history and physical examination
    - Laboratory testing
    - Preventive health and extended services
    - Referrals made

Refugee Medical Examination Protocol			
Activity	**All**	**Adults**	**Children**
History (Includes review of overseas medical records)	✓		
Physical exam and review of systems (Includes mental health, dental, hearing, and vision screening; nutritional, reproductive assessment; health education and anticipatory guidance, etc.)	✓		
Complete blood count with differential	✓		
Urinalysis	✓		
Serum chemistries		✓ If indicated by signs, symptoms, comorbidities, or risk	
Pregnancy testing		✓ Women of childbearing age; using opt-out approach	✓ Girls of childbearing age; using opt-out approach or with guardian's consent
HIV testing (using opt-out approach)	✓		
Hepatitis B testing	✓	✓ All adults 18 years and older should be screened for hepatitis B, if not previously tested. ✓ All pregnant individuals	All children and adolescents <18 years of age if not previously tested and have incomplete vaccination history
Hepatitis C testing		✓	✓ With risk factors
Blood lead level – initial screening		✓ Pregnant or lactating women and girls	✓ 6 months to 16 years
Blood lead level - Follow-up testing three to six months after initial screening			All infants and children ≤ 6 years of age, regardless of initial screening result
Assay of iron			✓ 6 months to 6 years when iron deficiency or overload suspected
Syphilis testing		✓ 18 – 45 years if no overseas results are available Individuals with risk factors	✓ With risk factors
Syphilis confirmation testing		✓ With positive VDRL or RPR tests	✓ With positive VDRL or RPR tests
Chlamydia/gonorrhea testing		✓ 18-24 years who do not have documents pre-departure testing. Individuals with risk factors	✓ With risk factors
Newborn screening tests			✓ Within first year of life

Immunization assessment	✓		
Tuberculosis screening	✓		
Stool ova and parasite testing		✓ Who had contraindications to albendazole at pre-departure (e.g., pregnancy)	✓ Who had contraindications to albendazole at pre-departure (e.g., under 1 year)
Strongyloidiasis presumptive treatment or serology		✓ Who did not receive pre-departure presumptive treatment	✓ Who did not receive pre-departure presumptive treatment
Schistosomiasis presumptive treatment or serology		✓ From sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pre-existing seizures)	✓ From sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., under 4 years)
Malaria presumptive treatment or testing		✓ From sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., pregnant, lactating)	✓ From sub-Saharan Africa who had contraindications to presumptive treatment at pre-departure (e.g., < 5 kg)
Vitamins		✓ With clinical evidence of poor nutrition	✓ 6 months to 5 years of age; 5 years and older with clinical evidence of poor nutrition

Medical History and Physical Examination Guidelines

A critical component of the medical screening is the history and physical examination, which includes a review of overseas medical records and of all systems to assess refugees' immediate health needs.

The domestic medical screening is likely a refugee's first routine medical encounter with the U.S. healthcare system and is an opportunity to begin establishing a trusting patient-provider relationship. It is critical to use qualified medical interpreters for any patient with limited English proficiency. Individuals should be assured that this confidential medical visit is for their health, does not have any regulatory purposes and will not affect their resettlement or visa status. During the initial screening appointment, providers should review overseas medical documents, address a refugee's immediate health concerns and priority needs as well as obtain a detailed history, including documentation of standard past medical history, medications, allergies and social and family history. Additionally, a thorough history must include aspects unique to refugees, such as a history of toxic environmental exposures, dietary history and travel/geographic history.

The purpose of taking the medical history is to record any significant past or current medical condition or disability, preventive care (e.g., immunizations, dental care, etc.) and any relevant family history. During this medical history process, it may be possible to detect an obvious speech or hearing problem and to assess the patient's mental status. Historical events may provide clues to the refugee's risk for certain medical conditions, psychological problems and other nutritional or growth abnormalities.

All medical history and physical examination information, including any abnormal findings, is to be documented in the refugee's medical record. Document referrals for all necessary continued treatment and care.

Medical History

Medical history and physical examinations are to be completed for all refugees. A detailed past medical history may be difficult to obtain due to lack of recall, accurate prior diagnoses, lack of access to medical care overseas or differing cultural beliefs around health and disease. Items more likely to be recalled and reported are prior hospitalizations, episodes of severe illness, known chronic conditions, previous injuries, surgeries (including dental procedures), circumcision, and blood transfusions. Additionally, review all available overseas medical records. The overseas medical record review should include, but is not limited to, immunization records, individually carried documents and the following Department of State (DS), United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration (IOM) forms*:

- Pre-Departure Medical Screening Form
- DS-2054 Report of Medical Examination by Panel Physician
- DS-3026 Medical History and Physical Examination Worksheet
- DS-3030 Tuberculosis Worksheet
- DS-3025 Vaccination Documentation Worksheet

**Contact the Indiana Refugee Health Program if overseas medical forms are not available in the Immigrant TB and All Refugee Application (ITARA2) database.*

Obtain a detailed medical history. A complete medical history should include:

- Current and/or past symptoms and medical conditions, including:
    - Recent fever
    - Weight loss or gain
    - Night sweats
    - Pulmonary complaints
    - Diarrhea or abdominal complaints
    - Pruritis
    - Skin lesions/rashes
    - Other known medical problems, chronic health conditions, and recent illnesses
- Past and current disabilities, injuries/accidents, surgical procedures, blood transfusions
- Menstrual, pregnancy (including live), contraception and OB history, for women
- Allergies (drugs and environmental)
- Medications
    - Prescription
    - Nonprescription (over the counter)
    - Traditional and/or herbal remedies and therapies with special attention to any products that may have potential drug interactions, teratogenicity or be contaminated with toxins such as lead
    - Determine if the refugee has adequate medications on-hand
- Nutritional status
    - Type of diet
    - Past periods of food insecurity

    - History of supplement intake and limited consumption of fruits, vegetables and/or meat
    - Current or past breastfeeding, for children
- Social history
    - Migration history (from birth to present, including route leading to U.S. arrival)
    - Current living situation and family structure should be ascertained
    - Occupational history may raise suspicion about environmental and chemical exposure
    - Substance use, including alcohol, tobacco, illicit drugs and other substances commonly used in other areas of the world (e.g., betel nut, sheesha/argileh, and khat)
    - Education level and literacy for children and adolescents may assist in placement in the appropriate school year
- Family history, especially information about acute illnesses, and major diseases, such as:
    - Diabetes
    - Sickle-cell
    - Anemia
    - Hypertension
    - Other conditions that indicate a communicable health condition or condition that will affect the family's resettlement
- Immunization history (see the immunization section for additional information)

Physical Examination

Physical examinations are to be completed for all refugees. The physical examination can identify important health issues that need to be addressed at the domestic medical screening and chronic conditions that require further evaluation and management.

The physical exam should involve a comprehensive clinical evaluation and a head-to-toe review of all systems. A complete physical examination includes:

- Growth and development measures (height/length in inches, weight in pounds and head circumference in centimeters, for children)
- Vital signs (temperature, heart rate, respiratory rate and blood pressure). Clinicians who see children at the domestic medical screening should refer to Pediatric Blood Pressure Norms for additional information (www.nhlbi.nih.gov/files/docs/guidelines/child_tbl.pdf).
- Cardiac auscultation
- Respiratory examination (particularly in individuals with pulmonary or constitutional signs or symptoms)
- Abdominal examination, including assessment for hepatic and splenic enlargement
- Ear, nose, throat (ENT)
- Oral examination should be performed for all new arrivals. Many refugees have not had access to regular dental services. Some refugees may have practiced traditional oral hygiene methods, such as using a teeth-cleaning stick or locally prepared toothpaste. Basic dental hygiene, including daily brushing and flossing, should be introduced, or revisited. Full lymph node exam.
- Neurological evaluation

- Skin examination may reveal traditional healing techniques which may indicate current or past illness.
- Mental health assessment
- Visual acuity: Perform formal vision screening in all patients ≥3 years of age at the initial domestic medical screening. Use of alternate vision charts may be needed if the individual cannot identify letters of the English alphabet. Provide referral for abnormal findings.
- Hearing screening, using whisper test. A hearing screening should be performed using office audiometry for all refugees ≥4 years of age. If there are concerns of hearing issues in children <4 years of age, they should be referred for a formal audiologic evaluation. Provide referral for abnormal findings.
- Gross oral screening (provide referral for abnormal findings)
- Postural assessment
- Genital exam: This may be deferred to the primary care setting after the patient has developed a trusting relationship with the care provider.

Mental Health Screening

All refugees should be evaluated for mental health concerns.

- Review overseas records for documentation of type and severity of any trauma or abuse, physical and mental disorders with associated harmful behaviors and substance use disorders.
- Ask directly about symptomology, functionality and suicidal ideation as part of an integrated history and physical examination, helping to minimize stigmatization.
- For refugees age ≥ 14, screen using the RHS-15 validated assessment tool once during the first 90 days after U.S. arrival.
- Screen for substance use and educate about possible legal consequences of these behaviors in the U.S.
- For those needing mental health or substance use support, develop a care plan and/or make appropriate referrals.

Further mental health screening guidance is provided in the CDC's Guidance for Mental Health Screening during the domestic Medical Examination for Newly Arriving Refugees, which can be found at: https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html.

Laboratory Testing Guidelines

All laboratory testing information, including any abnormal findings, is to be documented in the refugee's medical record. Document referrals for all necessary continued treatment and care.

Complete Blood Count with Differential

Complete a Complete Blood Count (CBC) with Differential, including red blood cell indices and eosinophilia count for all refugees.

Urinalysis

Complete a urinalysis (U/A) test for all refugees old enough to provide a clean-catch urine specimen.

Serum Chemistries

No evidence supports universal screening of asymptomatic refugees for electrolyte and other chemistry abnormalities. However, a basic panel including blood urea nitrogen and creatinine should be considered if indicated by signs, symptoms or comorbidities. A basic panel may also be considered in certain groups with high rates of chronic renal disease, such as the Hmong.

Pregnancy Testing

Complete a pregnancy test, using the opt-out approach, for women of childbearing age. Complete a pregnancy test, with guardian consent or using the opt-out approach, for girls of child-bearing age. (Child-bearing age, in general, is defined as ages 15-44.)

Refugees may have had limited access to contraception and may not be aware of their options. Clinicians are encouraged to discuss family planning and provide information about available contraceptive methods, including accessibility, efficacy and cost.

HIV Testing

Complete an HIV test, using the opt-out approach, for all refugees. Efforts should be made to understand the context of HIV testing, diagnosis and care within specific cultural and societal norms.

Refugees should be clearly informed orally or in writing that HIV testing will be performed. Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions. With such notification, consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as other screening or diagnostic tests.

When a refugee declines an HIV test, this decision must be documented in the patient's medical record, per Indiana Code IC 16-41-6-1. Additionally, a pregnant woman who declines an HIV test must do so in writing, per Indiana Code IC 16-41-6-8.

Special considerations:

- Specific testing for HIV-2 should be conducted for refugees who screen positive for HIV and are native to or have transited through the following countries: Angola, Benin, Burkina Faso, Cape Verde, Côte d'Ivoire (Ivory Coast), Gambia, Ghana, Guinea, Guinea Bissau, Liberia, Mali, Mauritania, Mozambique, Niger, São Tomé, Senegal, Sierra Leone and Togo.
- Children <18 months of age who test positive for HIV antibodies should receive further testing with DNA or RNA assays. Results of positive antibody tests in this age group can be unreliable because they may detect persistent maternal antibody.
- All children born to or breast-fed by an HIV-infected mother should receive chemoprophylactic trimethoprim/sulfamethoxazole beginning >6 weeks of age until they are confirmed to be uninfected.

- The identification and treatment of HIV-infected pregnant women can prevent HIV infection in their infants. All refugee women who are pregnant should undergo routine HIV screening as part of their post-arrival and prenatal medical screening and care.

All HIV-infected individuals should receive culturally sensitive and appropriate counseling in their primary spoken language. HIV-infected individuals must be informed of the available treatment and referral options available to them. Appropriate referral for care, treatment, and preventive services should be made for all individuals confirmed to be HIV-infected. Referrals to an infectious disease specialist and IDOH's HIV Care Coordination program should be made.

Information about the Indiana Department of Health's HIV Care Coordination Program can be found at: https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/hiv-non-medical-case-management/.

Hepatitis B Testing

In accordance with national screening recommendations, all newly arriving adult refugees age ≥18 years should be screened for hepatitis B, if not previously tested. Previously, HBsAg testing was recommended for those from intermediate and high endemicity countries, if not previously tested.

All pregnant women should be screened during each pregnancy, preferably in the first trimester regardless of vaccination status or history of testing. Of note, general pediatric recommendations remain unchanged.

Hepatitis B surface antibody (anti-HBs) and hepatitis B core antibody (anti-HBc) are also to be completed. Document the day, month, and year each serology is drawn. For those from countries with <2% prevalence of chronic HBV infection, testing should be done if the refugee is high-risk (e.g., history of sexual abuse, IDU, household contacts, etc.)

Documented overseas HBsAg results may be accepted. If negative and the vaccine series has been completed, no other testing needs to be done unless at high risk of future exposure.

All refugees with positive hepatitis B surface antigen (HBsAg) test result are to be referred for additional medical evaluation and possible treatment.

https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/hepatitis-screening-guidelines.html

**NOTE: Serology must be drawn for hepatitis B before vaccines are administered.*

Hepatitis C Testing

Complete a hepatitis C antibody (anti-HCV) for all adult refugees.

Complete a hepatitis C antibody (anti-HCV) for children (<18 years old) who have risk factors (e.g., children born to hepatitis C-positive mothers, unaccompanied refugee minors, injection and intranasal drug use, chronic hemodialysis, HIV infection, signs and symptoms of liver disease, household contacts with HCT, history of female genital mutilation, etc.)

Refugees with a positive anti-HCV test should receive an HCV RNA PCR test to determine if they are currently infected.

Blood Lead Level

Complete blood lead level tests for children 6 months to 16 years of age. Older adolescents (over 16 years of age) should also be tested if there is a high index of suspicion (siblings with EBLL, suspected environmental exposures, etc.). Pregnant and lactating women and adolescent girls should be screened for lead exposure, and provided with appropriate follow-up, as indicated.

According to the CDC, BLL of >3.5 µg/dl is abnormal and indicates lead poisoning. Elevated capillary screening results should be confirmed with blood drawn by venipuncture.

An initial blood lead test is recommended for all refugee infant and children ≤16 years and for all pregnant women and lactating women and girls. An initial blood lead testing is also recommended for refugee adolescents older than 16 years of age if there is a high index of suspicion or clinical sign or symptoms of lead exposure.

Follow-up blood lead testing is recommended in three to six months, for all refugee infants ≤6 years, regardless of initial screening result. A follow-up blood lead test is also recommended for refugee children and adolescents 7-16 years of age who have a risk factor (e.g. sibling with BLL at or above 3.5 µg/dL, environmental exposure risk factors), regardless of initial test result. Follow-up blood lead testing should also be recommended to pregnant or lactating adolescents (<18 years of age) who had BLLS at or above 3.5 µg/dL at initial screening.

Recommend and encourage the use of daily pediatric multivitamins with iron for refugee children 6 months to 6 years of age.

Further lead screening guidance is provided in the CDC's Screening for Lead during the domestic Medical Examination for Newly Arriving Refugees, which can be found at: http://www.cdc.gov/immigrantrefugeehealth/guidelines/lead-guidelines.html.

Assay of Iron

Complete an assay of iron for refugee children ages 6 months to 6 years when iron deficiency or iron overload is suspected.

Syphilis Testing

Complete a syphilis test, all patients of 18-45 years of age if no overseas result is available. And for all patients with risk factors and/or symptoms. Risk factors include, but are not limited to, the following:

- Sexually active or history of sexual assault
- Mother who tests positive for syphilis
- From countries that are endemic for Treponema subspecies (e.g., yaws, bejel, pinta)

Venereal Disease Research Laboratory (VDRL), or rapid plasma reagin (RPR), or equivalent test is to be used for syphilis testing.

Syphilis Confirmatory Testing

Complete a syphilis confirmation test for adults and children with positive VDRL or RPR tests. Fluorescent Treponema antibody absorbed (FTA-ABS) test, Treponema pallidum passive particle agglutination (TP-PA) assay, or enzyme-linked immunosorbent assay (EIA) is to be used for confirmatory testing.

Refugees with positive confirmatory results should be referred to the STI clinic.

Ref: Updates to the CDC Sexual and Reproductive Health Screening Guidance for Newcomers July 31, 2023: https://www.cdc.gov/std/treatment-guidelines/default.htm.

Further evaluation, including evaluation for neurosyphilis, and treatment should be instituted according to current CDC guidelines, found at: www.cdc.gov/std/treatment/.

Chlamydia/Gonorrhea Testing

Complete a chlamydia/gonorrhea test for all patients of 18-24 years of age who do not have documented pre-departure testing.

Complete a chlamydia/gonorrhea test for all patients with risk factors and/or symptoms.

Risk factors include, but are not limited to, the following:

- New sexual partner or multiple sexual partners
- Sex partner with concurrent partners
- Sex partner who has a sexually transmitted infection
- Adults and children who have a history of sexual assault*
- Female refugees with abnormal vaginal or rectal discharge, intermenstrual vaginal bleeding or lower abdominal or pelvic pain
- Male refugees with urethral discharge, dysuria, or rectal pain or discharge

*Ref: Updates to the CDC Sexual and Reproductive Health Screening Guidance for Newcomers July 31, 2023: https://www.cdc.gov/std/treatment-guidelines/default.htm.

Newborn Screening Tests

Newborn screening tests are to be completed for children within the first year of life. Newborn screenings are to be completed according to the Indiana Department of Health's standards, found at: https://www.in.gov/health/gnbs/information-for-providers/provider-education/, and Indiana Code IC 16-41-17, Chapter 17: Prevention and Treatment Programs: Examination of Infants for Phenylketonuria, Hypothyroidism, and Other Disorders, found at: http://iga.in.gov/legislative/laws/2022/ic/titles/016#16-41-17.

Refer to the Newborn Screening Program or a primary care provider for the provision of newborn screening services.

Preventive Health and Extended Services Guidelines

All preventive health and extended services information, including any abnormal findings, is to be documented in the refugee's medical record. Document referrals for all necessary continued treatment and care.

Immunizations

Assess all refugees for the need for immunization. Provide immunizations for adults and children with incomplete or missing immunization records. The Indiana Refugee Health Program is following the Guidelines for the U.S. Domestic Medical Examination for Newly Arriving Refugees which follows the Advisory Committee on Immunization Practices (ACIP): https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/special-situations.html.

Evaluate immunization history, review overseas documentation and record valid doses, lab evidence of immunity or history of disease. Immunizations administered outside the United States can be accepted as valid if the schedule (minimum ages and intervals) was similar to the IDOH immunization schedules.

Initiate all necessary age-appropriate vaccines per IDOH adult and childhood vaccine schedules. Complete any series that has been initiated. Do not restart a vaccine series. If the refugee has no documentation, assume they have not been vaccinated and initiate an age-appropriate vaccination schedule.

COVID-19 vaccination, if not already completed overseas, should be encouraged, and arranged as part of the medical screening process. Follow the latest CDC guidance to determine whether vaccination is appropriate. Provide care coordination to address any barriers to vaccination. Additional nurse visits, interpretation, or transportation may be arranged as needed to complete a COVID-19 vaccine series.

Serologic testing for immunity is an acceptable alternative for certain antigens when it is believed the refugee likely had a previous infection that conveyed immunity or received a full series of vaccine but did not have appropriate vaccination records. It is likely cost effective for varicella and hepatitis A.

NOTE: Serology must be drawn for hepatitis B before vaccines are administered. Hepatitis B vaccination can cause a false positive HBsAg for up to 30 days.

Document immunity based on exam, history or serologic testing. Document each immunization administered. Record the month, day and year of each immunization.

Provide all refugees with a childhood or adult immunization document, with completed documentation of all known past and current immunizations. Update this document at each visit when immunizations are given. Educate refugees of the need to bring their immunization documentation to all medical visits, including the civil surgeon evaluation required for change of status applications. Emphasize the need to complete the vaccine series.

IDOH immunization schedules can be found at: https://www.in.gov/health/immunization/.

Tuberculosis

Complete tuberculosis screening for all refugees, regardless of Bacillus Calmette-Guérin (BCG) history, unless medically contraindicated.

All refugees should receive a domestic TB screening test unless they have reliable documentation of either 1) a previously positive Interferon-Gamma Release Assay (IGRA) or 2) treatment for TB disease or latent TB infection (LTBI).

Either an IGRA or a tuberculin skin test (TST) may be used, although an IGRA is preferred. IGRA is appropriate for refugees 2 years of age and older. Record the date of IGRA and result. Tuberculin skin test (TST) is appropriate for refugees of all ages. The skin test should be read by qualified personnel between 48-72 hours. Perform and record the date the TST is placed, the date read and diameter of induration in millimeters.

A chest x-ray should be performed for all individuals with a positive TST or IGRA. A chest x-ray should also be performed for those individuals classified as TB Class A or TB Class B1 during the overseas exam and for those who have symptoms compatible with TB disease, regardless of TB screening test results.

Refer all positive test results or patients with symptoms compatible with TB disease to the local health department's TB case management to ensure proper follow-up and treatment.

Detailed TB information can be found in the in the ATS/CDC/IDSA Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, located at: https://academic.oup.com/cid/article/64/2/e1/2629583.

Stool Ova and Parasite

Review records for presumptive treatment with albendazole. A schedule of countries with pre-departure treatment programs can be found on the CDC website: https://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf.

If there is documentation of pre-departure treatment, perform an absolute eosinophil count (CBC with differential) only.

If there is no documentation of pre-departure treatment, perform two O&P examinations on separate morning stools and a CBC with differential for eosinophil count.

Complete stool ova and parasite test for adults who had contraindications to albendazole at pre-departure (pregnancy, cysticercosis or neurocysticercosis, seizures or neurological disorders of unknown etiology). Complete stool ova and parasite test for children who had contraindications to albendazole at pre-departure (e.g., under 1 year of age). Presumptive treatment is an acceptable alternative to testing, provided the contraindication has resolved.

Collect stool samples for O and P if height or weight are less than fifth percentile and/or diarrhea, anemia, gastrointestinal symptoms are present.

If parasites are identified, one stool specimen should be submitted two to three weeks after completion of therapy to determine response to treatment.

If parasites are not identified in a single specimen AND the eosinophil count is high, consider repeat stool specimens. High eosinophil counts may be an indication that there is an undiagnosed parasitic infection.

Giardia

Refugees are not presumptively treated for giardia before departure.

Testing is recommended for those with symptoms. Symptoms of chronic infection may include diarrhea, anorexia, poor weight gain/failure to thrive/malnutrition, abdominal distension and/or flatulence. Giardiasis is not associated with eosinophilia.

Stool ova and parasite testing has low sensitivity. Perform stool antigen testing if the refugee is symptomatic for gardia.

Strongyloidiasis

Nearly all refugees (regardless of country of origin) are at risk for Strongyloides and should be tested or presumptively treated with Ivermectin.

Review records for presumptive treatment with Ivermectin. A schedule of countries with pre-departure treatment programs can be found on the CDC website: https://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf.

Refugees who received presumptive treatment do not need to be tested for Strongyloides, although those with an elevated eosinophilia count should be monitored for persistent eosinophilia. Treatment is not 100% effective, and continuation or recurrence of signs and symptoms should prompt further investigation and may necessitate repeat treatment.

Complete Strongyloidiasis presumptive treatment for adults and children who did not receive pre-departure presumptive treatment, unless contraindicated (children weighing <15kg, pregnancy or breastfeeding an infant <1 week old, from a Loa loa endemic country).

Testing with Strongyloides IgG serology is an acceptable alternative.

Ivermectin is the drug of choice for treatment of Strongyloidiasis but is contraindicated in refugees infected with Loa loa. Loa loa is endemic in certain West and Central African countries. Refugees from Loa loa endemic areas should receive serological testing for Strongyloides. If positive, a thin and thick blood smear between 10 a.m. and 2 p.m. for Loa loa microfilaria should be performed to rule out infection before treatment with ivermectin.

Schistosomiasis

Refugees from sub-Saharan African countries (except Lesotho) are at risk for schistosomiasis and should be tested or presumptively treated with praziquantel.

Review records for presumptive treatment with praziquantel. A schedule of countries with pre-departure treatment programs can be found on the CDC website: https://www.cdc.gov/immigrantrefugeehealth/pdf/intestinal-parasites-overseas.pdf.

Refugees who received presumptive treatment do not need to be tested for schistosomiasis, although those with an elevated eosinophilia count should be monitored for persistent eosinophilia. Treatment is not 100% effective, and continuation or recurrence of signs and symptoms should prompt further investigation and may necessitate repeat treatment.

Complete schistosomiasis presumptive treatment for adults and children who did not receive pre-departure presumptive treatment, unless contraindicated (children <4 years, cysticercosis or neurocysticercosis, seizures or neurological disorders of unknown etiology).

Testing with schistosoma IgG serology is an acceptable alternative. Previous treatment does not decrease schistosoma IgG levels, so persistently positive schistosome antigen-specific IgG results do not necessarily indicate current infection and should not be used to monitor treatment success.

Malaria

Malaria evaluation applies only to refugees from sub-Saharan Africa, unless symptomatic or specifically indicated.

If symptomatic, complete malaria testing.

All refugees arriving from sub-Saharan Africa receive presumptive antimalarial treatment prior to departure, unless contraindicated. The contraindications are: 1) pregnant women 2) women breastfeeding infants weighing < 5kg 3) infants weighing < 5kg and 4) known antimalarial medication allergy.

For refugees from sub-Saharan Africa, review pre-departure treatment information. Refugees who have received the recommended antimalarial drug or drug combination do not need further evaluation unless they have signs or symptoms of the disease.

If the refugee did not receive pre-departure treatment and has been in the U.S. for < 90 days:

- Preferred: Provide presumptive malaria treatment using atovaquone-proguanil or artemether-lumefantrine, unless contraindicated.
- Alternative: Test for malaria infection. Polymerase chain reaction (PCR) is the most sensitive test and is the preferred method to test for asymptomatic or subclinical malaria. If PCR is not available, examination of blood smears (x3) is the next most sensitive option.

Vitamins

Provide vitamins for adults with clinical evidence of poor nutrition. Provide age-appropriate multivitamins to children 6-59 months of age, and to children 5 years of age and older with clinical evidence of poor nutrition.