

Refugee/Immigrant Health Assessment Outcome Report

Complete one form per family that did not receive an assessment.

Local Public Health Agency: _____

Contact Person: _____

Phone: _____ Date: _____ / _____ / _____

Name (Last, First, Middle)	Date of Birth	Alien #	Refugee / Immigrant Class A/B1/B2/B3 TB	Outcome & Screening Status*

- *Outcome and Possible Screening Status Codes** – Please select only one outcome code per person.
- 1 = moved out of state (out of MN)**
 - 8 = never arrived to MN
 - 2 = moved to another county
 - 9 = located but numerous attempts to schedule failed
 - 3 = moved to unknown destination
 - 10 = died before screening
 - 4 = unable to locate due to invalid contact information
 - 11 = VOT/asylees: already connected to care
 - 5 = missed appointment/no show
 - 12 = secondary refugee: no insurance
 - 6 = was screened elsewhere/unable to obtain results
 - 13 = secondary refugee: completed out of state
 - 7 = refused screening
 - 14 = secondary refugee: notification after time limit

- **If Outcome is 1**, select one of these screening status codes for each.
- A = screening not started
 - C = completed screening, needs **only** follow-up***
 - B = incomplete screening, needs medical follow-up***
 - D = completed screening, needs Civil Surgeon services***

*****If Outcome is 1 and screening status code is B, C, or D**, please attach the name and contact information of the clinic that initiated the refugee health assessment.

If refugee(s) moves to another county (Outcome 2), please send a copy of outcome report to new county and MDH. MDH will transfer overseas medical records in eSHARE once notified.

Check box if new county is notified (send copy of outcome report)

Return this form to MDH:
Mail: Refugee and International Health Program
 Minnesota Department of Health
 PO Box 64975
 St Paul, MN 55164-0975
Fax: 1-800-311-9194
Email:¹ refugeehealth@state.mn.us

Include the family’s forwarding address and phone #:

