Medical Forms:

- Appendix 4.3.A: Intake Screening
- Appendix 4.3.B: Physical Examination/Health Appraisal
- Appendix 4.3.C: Medical Transfer Summary

INTAKE SCREENING

Identification

Patient was identified by (check 2 sources): ☐ Wrist Band ☐ Picture ☐ Verbally ☐ ID Badge ☐ Other:
Chaperone Present? ☐ Yes ☐ No If yes, give chaperone name:
Date of arrival at facility: Time of arrival: Time of initial screening:
If transferred from another facility, did medical transfer summary accompany the patient? ☐ Yes ☐ No ☐ Not Applicable
Was the Pre-Screening Note reviewed? ☐ Yes ☐ No

Subjective

Communication Assessment:

What language do you speak? ☐ English ☐ Spanish ☐Other:
Interpreter provided? ☐ Yes ☐No If yes, name or INT number:
If No, patient speaks: ☐ English fluently ☐ Provider fluent in patient's native language ☐ No interpreter available at this time
Do you have any difficulty with: ☐ Hearing ☐ Speech ☐ Vision Check if yes. If yes, what accommodation do you need to help you read, communicate, or navigate the facility?

Disability Screening:

Do you have any difficulty with walking, standing, or climbing stairs? ☐ Yes ☐ No If yes, explain:
Do you have any difficulty reading or writing? ☐ Yes ☐ No If yes, explain:
What was the highest grade completed in school?
Do you have any difficulty understanding directions? ☐ Yes ☐ No If yes, explain:

Medical Screening:

How do you feel today? (Explain in his/her own words)			
Are you currently having any pain? ☐ Yes ☐ No If yes, complete pain assessment below			
a. Character of pain:	b. Location:	c. Duration:	d. Intensity: (0-10 pain scale)
e. What relieves pain or makes it worse?			
Do you have any current or past medical problems? ☐ Yes ☐ No If yes, explain:			

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Medical Screening (continued)

Are you currently or in the past year have you taken any medication on a regular basis, including over the counter and herbal? ☐Yes ☐No If yes, list medications:
Do you have your medications with you? ☐Yes ☐No If yes, list medications and disposition:
Do you have any allergies to medication or food? ☐Yes ☐No If yes, list all:
Are you now or have you ever been treated by a doctor for a medical condition to include hospitalizations, surgeries, infectious or communicable diseases? ☐Yes ☐No If yes, explain:
Do you now or have you ever had Tuberculosis (TB)? ☐Yes ☐No
In the past 2 months, have you experienced any of the following signs or symptoms continuously for more than 2 weeks: Cough? ☐Yes ☐No Coughing up blood? ☐Yes ☐No Chest pain? ☐Yes ☐No Loss of appetite? ☐Yes ☐No Fever, chills, or night sweats for no known reason? ☐Yes ☐No Unexplained weight loss? ☐Yes ☐No
Symptom screening with positive responses(s) is concerning for active TB: ☐Yes ☐No If yes, explain:
Referred to provider for further evaluation. ☐Yes ☐No
Have you had any recent sudden changes with your vision or hearing? ☐Yes ☐No If yes, explain:
Do you have any specific dietary needs? ☐Yes ☐No If yes, explain:
Have you traveled outside of the US within the past 30 days? ☐Yes ☐No If so, where?
Have you ever had or have you ever been vaccinated against Chicken Pox? ☐Yes ☐No ☐Admits prior infection

LGBT Screening

Are you gay, lesbian, bisexual, transgender, intersex or gender non-conforming? ☐ Yes ☐ No
If transgender, what is your gender self-identification?

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Female Patient Only

Are you pregnant? ☐ Yes ☐ No ☐ Not Applicable If yes, date of last menstrual period:
Are you currently breastfeeding? ☐ Yes ☐ No If yes, when is the last day you breastfed?
Have you had unprotected sexual intercourse in the past 5 days? ☐ Yes ☐ No If yes, would you like to speak to a medical provider about emergency contraception to prevent a possible pregnancy? ☐ Yes ☐ No **If yes, contact a medical provider immediately for guidance.**

Oral Screening

Are you having any significant dental problems? ☐ Yes ☐ No If yes, explain:
Do you have dentures, partials, braces, etc? ☐ Yes ☐ No If yes, do you have these items with you?

Mental Health Screening

Have you ever been diagnosed with mental illnesses or mental health conditions? ☐ Yes ☐ No If yes, what illness?
Have you ever received counseling, medication or hospitalization for mental health problems (to include outpatient treatment)? ☐ Yes ☐ No If yes, explain. **Refer for follow-up and appropriate treatment as necessary.**
Do you have a history of self-injurious behavior? ☐ Yes ☐ No If yes: ☐ Cutting ☐ Self-mutilation ☐ Other Most recent **If yes, refer for follow-up and appropriate treatment as necessary.**
Have you ever tried to kill or harm yourself? ☐ Yes ☐ No If yes, when did the attempt occur? Method: ☐ Gun ☐ Hanging ☐ Cutting skin ☐ Pills ☐ Other **If attempt was within the last 90 days, make referral to mental health immediately.**
Are you currently thinking about killing or harming yourself? ☐ Yes ☐ No **If yes, make referral to mental health immediately.**
Do you have a history of assaulting or attacking others? ☐ Yes ☐ No
Do you know of someone in this facility whom you wish to attack or harm? ☐ Yes ☐ No If yes, who is this person? **If yes, make referral to mental health immediately.**
Do you now or have you ever heard voices that other people don't hear, seen things or people that others don't see, or felt others were trying to harm you for no logical or apparent reason? ☐ Yes ☐ No If yes, explain:

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Sexual Abuse and Assault Screening

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Have you been a victim of physical or sexual abuse or assault? ☐ Yes ☐ No If yes, explain: **If yes, refer for medical or mental health evaluation as appropriate.**
Do you feel that you are in danger of being physically or sexually assaulted while you are in custody? ☐ Yes ☐ No If yes, explain: **If yes, refer for follow-up and appropriate treatment as necessary.**
Have you ever sexually assaulted or abused another person? ☐ Yes ☐ No If yes, explain: **If yes, refer for medical or mental health evaluation as appropriate.**

Trauma History Screening

Have you had a physical or emotional trauma due to abuse or victimization? ☐ Yes ☐ No
Have you ever experienced, witnessed or been confronted with an event that involved actual or threatened death or serious injury (can include domestic violence, sexual assault, robbery, natural disaster, war, serious illness, terrorism). ☐ Yes ☐ No If yes, answer the following: • Was your response to this event intense fear, helplessness or horror? ☐ No ☐ Some ☐ Moderate ☐ Extreme • Has this experience caused significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme • Has it affected your interpersonal relationships, work or other areas? ☐ No ☐ Some ☐ Moderate ☐ Extreme • Is this experience currently causing significant distress or impairment in your life? ☐ No ☐ Some ☐ Moderate ☐ Extreme **If the patient experienced any of the above, refer for follow-up and appropriate treatment as necessary.**

Cultural/Religious Assessment

Is there anything important to know about your religious or cultural beliefs that are of concern to you while in detention? ☐ Yes ☐ No If yes, explain:

Substance Use/Abuse Screening

Have you ever been treated for drug and/or alcohol problems?	☐ Yes ☐ No
Have you ever suffered withdrawal symptoms from drug and/or alcohol use?	☐ Yes ☐ No
Are you able to stop using drugs or alcohol if you want?	☐ Yes ☐ No
Have you ever blacked out or experienced memory loss from drinking or drug use?	☐ Yes ☐ No
Have drug or alcohol use negatively impacted your life (family, work, relationships, criminal charges)?	☐ Yes ☐ No
If yes to any of the above questions, explain: **Refer for follow-up and appropriate treatment as necessary.**	

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Substance Use/Abuse Screening (continued)

In the past three months, have you used tobacco, alcohol, illegal drugs, or misused prescription drugs? ☐Yes ☐No

If yes, complete the following (refer for follow-up and appropriate treatment as necessary).

Substance Used/Route of Use	Date of Last Use	Amount/Quantity Last Used

Objective

Patient does not appear to have abnormal physical, mental, and/or emotional characteristics. ☐Yes ☐No

Patient does not appear to have barriers to communication. ☐Yes ☐No

Patient is oriented to: Person ☐Yes ☐No Place ☐Yes ☐No Time ☐Yes ☐No

If you observe any of the following, check the appropriate box and document findings below:

Appearance: ☐Sweating ☐Shaking/tremors ☐Anxious ☐Disheveled ☐Ill appearance

Findings:

Behavior: ☐Disorderly ☐Appropriate ☐Insensible ☐Agitation ☐Inability to focus/concentrate Findings:

State of Consciousness: ☐Alert ☐Responsive ☐Lethargic

Findings:

Ease of Movement: ☐Body deformities ☐Gait

Findings:

Breathing: ☐Persistent cough ☐Hyperventilation

Findings:

Skin: ☐Lesions ☐Jaundice ☐Rashes ☐Infestations ☐Nits (lice) ☐Bruises ☐Scars ☐

☐Tattoos Needle Marks or Indications of Drug Use Findings:

Developmental or Physical Disabilities: ☐Developmental Delay ☐Para/quadriplegia ☐Stroke ☐Amputation ☐Cardiac condition

Findings:

Assistive Devices: ☐Glasses/Contacts ☐Hearing aid(s) ☐Denture(s)/Partial(s) ☐Orthopedic brace ☐Prosthetic ☐Cane

Findings:

☐None Observed

Comments/Other Findings:

Vital Signs

T _____ P _____ Resp _____ BP _____ HT _____ WT _____ HCG Results: ☐Pos ☐Neg ☐N/A

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Assessment

Initial Medical Screening:

☐ No findings requiring referral
☐ Findings requiring referral identified. See disposition below.
☐ List all findings:

Plan

Disposition:

☐ General population
☐ General population with referral for: ☐ Medical ☐ Mental health care
☐ Isolation until medically evaluated
☐ Referral for immediate: ☐ Medical ☐ Mental health ☐ Dental care
Details of referral:

Care/Intervention/Follow-up:

☐ Physical examination/Health Assessment will be performed within 14 days.
☐ Physical exam will be scheduled for patient.
☐ Tuberculin Skin Test (TST) administered ☐ Left forearm ☐ Right forearm
☐ Chest X-Ray (CXR) completed with appropriate shielding
☐ TST or CXR not needed. Transfer Summary accompanying patient documents negative screening within timeframe allowed by policy.
☐ The following care/treatment was provided during this Intake Screening.

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Patient Education:

☐ Tuberculosis screening and need for tuberculin skin test (TST) or chest x-ray (CXR) explained to patient prior to performance.
☐ Access to medical, dental, and mental health care explained to patient as well as grievance process.
☐ Given the Dealing with Stress brochure in language.
☐ Given the Medical Orientation brochure in language.
☐ Given the Health Information brochures in language.
☐ Patient verbalized understanding of teaching or instruction provided.
☐ Patient was asked if he or she had any additional questions and all questions were addressed.
☐ Female ONLY: Educated and provided brochure describing female medical and mental health services related to pregnancy, terminated/miscarried pregnancies, contraception, family planning and age-appropriate gynecological health care.
☐ Other education provided:

Provider's Signature	Stamp / Printed Name	Date	Time
Reviewer's Signature	Stamp / Printed Name	Date	Time

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal

Patient was identified by (check 2 sources): □ Wrist Band, □ Picture, □ Verbally, □ ID Badge, □ Other _____
Chaperone Present? □ Yes □ No If yes, give chaperone name: _____

Communication Assessment:
What language do you speak? □ English, □ Spanish, □ Other: _____
Interpreter provided? □ Yes □ No If yes, Name or INT#:_____
Detainee speaks □ English Fluently; □ Provider fluent in patient's native language; □ No interpreter available at this time

Do you have any difficulty with □ hearing, □ speech or □ vision? Check if Yes.
If yes, what accommodations, do you need to help you read, communicate, or navigate the facility? _____

Subjective:

Current Significant Medical Problems	Date Problem began	Current Status

Current Medications including OTC and Herbal:

Name	Dose	Route	Frequency

Allergies:

Medications/Food/Environmental: List All: _____\

Pain Assessment

Are you currently in pain? □ Yes □ No If yes, pain began when?_____ Intensity: (0/10 scale)_____
Character of Pain:_____ Location:_____
Duration:_____
Has anything you have done or tried in the past relieved the pain or made it worse? □ Yes □ No
If yes, explain_____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Disability

Do you have any difficulty with walking, standing, or climbing stairs? □ Yes □ No
If yes, do you use a wheelchair, walker, cane or crutches? _____

Have you ever had an injury to your head or brain which resulted in the loss of consciousness and/or recurring headaches, dizziness, confusion or memory loss? □ Yes □ No If yes, when was the injury? mm/yyyy _____
Can you read? □ Yes □ No If yes, in which language? _____Do you have difficulty reading? □ Yes □ No
Can you write? □ Yes □ No If yes, in which language? _____Do you have difficulty writing? □ Yes □ No
What was the highest grade you completed in school? _____
Do you have difficulty understanding directions? □ Yes □ No
If yes, does someone normally assist you with any regular tasks of daily living? _____

Medical History Has a medical professional ever diagnosed you with any of the following?

☐Yes ☐No Asthma	☐Yes ☐No Cardiovascular disease	☐Yes ☐No Tuberculosis	Comment: **Type
☐Yes ☐No Cancer	☐Yes ☐No Kidney Disease	☐Yes ☐No Stroke	
☐Yes ☐No HIV	☐Yes ☐No Hyperlipidemia	☐Yes ☐No Hepatitis**	
☐Yes ☐No Seizures	☐Yes ☐No Diabetes	☐Yes ☐No Sexually Transmitted Infections**	
☐Yes ☐No Hypertension	☐Yes ☐No Sickle Cell Anemia		
Varicella □ Yes □ No ☐ Admits to prior infection ☐ Admits being vaccinated ☐ History denied at physical exam			
Other			

Surgical/Hospitalization History:

Surgery or reason for hospitalization	When (mm/yyyy)

Dental

Do you have any significant dental problems? ☐No, ☐Cavity, ☐ Broken tooth, ☐Infection, ☐Broken jaw, ☐ Other_____
Do you have any dental prosthesis? ☐None, ☐Full upper denture, ☐full lower denture, ☐partial denture upper, ☐partial denture lower, ☐braces, ☐retainer

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Family History

Asthma □ Yes □ No Hypertension □ Yes □ No Diabetes □ Yes □ No Cardiovascular Disease □ Yes □ No
Cancer □ Yes □ No Tuberculosis □ Yes □ No Stroke □ Yes □ No Other: _____
Breast or gynecological problems □ Yes □ No

Female Only

OB History:
Have you ever been pregnant? □No □Yes #Pregnancies_____ #C-Sections_____
#Live Births _____#Full Term_____#Pre-Term_____ #Abortions____ #Miscarriages_____ #Living_____
Are you pregnant? ☐No □Yes
Are you currently receiving prenatal care? □No □Yes Where? _____
Have you ever been told that you had a 'high risk' pregnancy? If yes, what was the reason?
_____
Are you currently breast feeding? □No □Yes
If yes, how old is the nursing child? _____ When was the last time you breast fed? (mm/dd/yyyy)_____

GYN History:
When was the first day of your LMP? _____ If more than 30 days, why?
_____
Do you have a history of breast or gynecological problems? □No □Yes Explain_____
Do you use birth control? □No □Yes What type? _____ When was the last time you used it? _____
When was your last PAP smear? _____ If known, results_____

Sexual Abuse and Assault/Vulnerabilities

Have you ever been a victim of physical abuse? □No □Yes
Have you ever been a victim of sexual abuse or assault? □No □Yes
If yes, refer patient for medical evaluation in two working days or for mental health evaluation in 72 hours.

Are you gay/ lesbian, bisexual, transgender, intersex or gender non- conforming? ☐Yes ☐No
If transgender, what gender do you identify with_____

Do you believe you are vulnerable to sexual abuse or assault in ICE custody? ☐Yes ☐No If yes, why?_____
If yes, implement treatment plan.

Have you ever been involved in an incident where you sexually abused others? ☐Yes ☐No
If yes, refer patient for medical evaluation in two working days or for mental health evaluation in 72 hours.

Mental Health

Do you have a history of:
Manic episodes ☐Yes ☐No Depression ☐Yes ☐No Psychotropic medications ☐Yes ☐No
Severe anxiety ☐Yes ☐No Psychosis ☐Yes ☐No Violence towards others ☐Yes ☐No
Suicide attempts/gestures ☐Yes ☐No

Are you currently having any mental health issues? ☐Yes ☐No If yes, explain problem and date problem began _____
_____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Social History

Drug Use History:

Have you used drugs other than those for medical reasons in the past 12 months? □No □Yes If yes, what?

PCP □No □Yes Ketamine □No □Yes Marijuana □No □Yes Prescription Opiates □No □Yes

LSD □No □Yes Ecstasy □No □Yes Methamphetamine □No □Yes

Heroin □No □Yes Route: Injected □No □Yes Intranasal □No □Yes Smoked □No □Yes

Cocaine □No □Yes Route: Injected □No □Yes Intranasal □No □Yes Smoked □No □Yes

When did you last use? _____ Are you having any withdrawal symptoms? □No □Yes If yes, which apply?

□Nausea □Vomiting □Diarrhea □Chills □Sweating □Insomnia □Aches & pains □ Anxiety

Have you ever gone through withdrawal from drugs? □No □Yes If yes, when? _____

Are you currently in a drug treatment program? □No □Yes If yes, Name of program? _____

Type of Program: □Detox □Methadone □Residential Treatment □Outpatient □12 Step□ Other

Alcohol Use History:

Do you drink alcohol? □ No □Yes If yes, type? □Beer □Malt liquor □Wine □Liquor

How often do you drink? □ Daily □Weekly □Monthly □Rarely

How much do you drink when you drink? _____

Do you notice over time that you need to drink more for the same effect? □No □Yes

When was your last drink? _____

Are you having any withdrawal symptoms? □No □Yes If yes, which apply? □Headache □Fever □Nausea

□Vomiting □Insomnia □Tremor □Hallucinations □Convulsions

Have you ever gone through alcohol withdrawal in the past? □No □Yes How long ago? _____

Have you ever been in treatment for alcohol use? □No □Yes If yes, when? _____

What type of program? □Outpatient □Inpatient

Have you ever been convicted for driving under the influence of alcohol? □No □Yes If yes, when? _____

Tobacco History:

Have you ever used tobacco products? □No □Yes If yes, please answer the following questions:

Do you currently use tobacco products? □No □Yes If yes, what type of products? □ Cigarettes □Cigar □Pipe □Chewing tobacco

How long have you used tobacco products? _____ How frequently did/do you use tobacco?_____

When did you last use tobacco products?_____

Are you having any withdrawal symptoms from not using tobacco? □No □Yes If yes, what symptoms are you experiencing?

□Cravings □Irritation □Anger □Increased Appetite □Weight Gain □Concentration Problems □Restlessness □Insomnia

□Anxiety

Preventative Medicine/Screening History

Have you had screening for cancer? ☐Yes ☐No When? (mm/yyyy) _____

What type screening & results if known? _____

Have you had a mammogram? ☐Yes ☐No When? (mm/yyyy)_____ Results, if known_____

Have you had a pap smear? ☐Yes ☐No When? (mm/yyyy)_____ Results, if known_____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

OBJECTIVE:

Vital Signs

T_____ P_____ R_____ BP_____ HT_____ WT_____
Visual Acuity (Snellen): Left_____ Right_____ Both_____
Hearing: □ Grossly intact □ Other_____

General Physical Examination

	R = Refused	NE = Not Evaluated	
General	R	NE	Findings:
ENT	R	NE	Findings:
Dental	R	NE	Findings:
Neurological	R	NE	Findings:
Cardiac	R	NE	Findings:
Pulmonary	R	NE	Findings:
Gastrointestinal	R	NE	Findings:
Genitourinary	R	NE	Findings:
Extremities	R	NE	Findings:
Skin	R	NE	Findings:
Comments/Other Findings:			

Mental Status Examination

Orientation	Alert □No □Yes Oriented to person □No □Yes Place □No □Yes Time □No □Yes
Perceptions/ Thought Content	Perceptual disturbances? □No □Yes If yes, □ Auditory hallucinations □ Visual hallucinations □ Delusions
Appearance	□ Appropriately dressed □ well groomed; □ Disheveled; □ Other
Posture	□ Erect; □ Stooped; □ Slouched; □ Other
Gait/Walk	□ Steady; □ Shuffle; □ Limp; □ Other
Movement	□ Appropriate; □ Tics; □ Repetitive; □ Rigid; □ Agitated; □ Slow; □ Other
Mood	□ Appropriate; □ Labile; □ Relaxed; □ Happy; □ Calm; □ Distressed; □ Angry; □ Agitated; □ Sad/Depressed; □ Fearful/Anxious; □Irritable, □ Other
Attitude	□ Cooperative; □ Uncooperative; □ Threatening; □ Evasive
Speech	□ Coherent; □ Incoherent; □ Pressured; □ Average speed; □ Rapid; □ Slow; □ Slurred; □ Mumbled; □ Talkative; □ Loud; □ Soft; □ Other
Intelligence	□ Appears normal; □ Appears developmentally delayed
Insight	□ Good; □ Impaired
Comments:	

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

Physical Examination/Health Appraisal (con't)

Assessment:

___Physical exam/health appraisal shows no significant medical, mental health or dental issues currently.

___Physical exam/health appraisal shows the following significant issues:

Plan:

Treatment including medications: _____
_____
_____
_____

Immunizations, Injections, Imaging, Labs:

Referrals:

Other

Preventative Medicine/Patient Education:
__Given the Staying Healthy brochure in the _____ language.
__Verbally given instruction on dental hygiene.
__Provided with instruction appropriate to patient's health needs.
__Patient verbalized understanding of teaching or instructions provided.
__Patient was asked if he/she had any additional questions, and any questions were addressed.
__Patient was instructed to return to medical clinic as needed.
__Patient was instructed to return to clinic for appointment.
__Health Assessment was rescheduled until [_____] to provide sign language interpreter for health assessment.
__Health Assessment was rescheduled until [_____] to provide foreign language interpreter for health assessment.
__Other:_____

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival:	DOB:
Facility:	Sex:

MEDICAL TRANSFER SUMMARY

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival at Sending Facility:	DOB:
Sending Facility:	Sex:

1. General Information:

Cleared for Travel by Ground Transportation: □ Yes □ No Date of Departure: _____

Cleared for Travel by Air Transportation: □ Yes □ No Final Destination, if known: _____

Reason for Transfer: □ Custody □ Medical Medical Escort required: □ Yes □ No If yes, type: □ Medical □ Psychiatric

2. Current Medical, Dental, and/or Mental Health Diagnoses/Problems: **URGENT**

_____

_____

_____

_____

3. Allergies: _____

4. Current Prescribed Medications: List All (Name, Dosage, Directions in layman's terms)

Check off Medication Required for Care en Route

Medication	Dose	# Sent	Route	Instructions for use (include proper time for administration)	Stop Date
☐					
☐					
☐					
☐					
☐					
☐					
☐					

5. TB Clearance Status for Transfer or Transportation

Screening Modality *(Check all that apply and document below)*: ☐ CXR ☐ TST ☐ IGRA ☐ Symptom Screen

CXR: Date: _____

TB Screening: ☐ Negative, not consistent w/TB ☐ Positive, consistent w/TB

TST: Administered Date**:** _____ **TST** Read Date: _____ Results: _____ mm induration

IGRA: Collection Date: _____ Results: ☐ Positive ☐ Negative ☐ Indeterminate

Symptom Screening Date:_____ Results: ☐ Positive ☐ Negative

Is the patient being treated for TB? ☐ No ☐ Yes, select options:

- ☐ Cleared for general detention population
- ☐ Not cleared for general detention population
- ☐ Being treated for TB, see attached TB Case Management documentation

Medical Transfer Summary (con't)

6. Healthcare Follow-Up:

Recent (within 6 months) Test Results: _____

Recent (within 6 months) Hospitalizations/Surgeries: _____

Recommended Future Lab Work: _____

Pending Specialty Appointment (s):_____

Recommended Specialty Appointment (s):_____

Requires Immediate Follow Up: _____

7. Special Needs Affecting Transportation: -- Use Standard Infection Control Precautions for all patients --

Are there any medical, dental, or mental health condition that restricts the length of time the patient can be on travel status? □Yes □No

Reason(s) and maximum length of travel time: _____

Does the patient have any special needs that escorting staff should be aware of? □Yes □No

If so, what? _____

Equipment provided by: □ Medical Authority □ Other_____ Equipment owned by: □ Medical Authority □ Other_____

Patient will keep equipment upon arrival at destination? □Yes □No

Is there any medical equipment required to accompany the patient during travel? ☐ Yes ☐ No

If so, what? _____

Are any special precautions required during transport? □Yes □No

Precautions needed for the patient: _____

Precautions needed for the escorting staff: _____

8. Additional Comments (Mark through if no comments are made): Attach additional pages or medical records as needed

9. Release from custody: Attach □ Instructions for Requesting Complete Medical Records
□ Community Resource Information, if applicable

Sending Facility Point of Contact: _____

Sending Facility Contact Number: _____

_____	_____	_____	_____
Completed by Provider Printed Name	Date	Time	Provider Signature

Last Name:	First Name:
A#:	Country of Origin:
Date of Arrival at Sending Facility:	DOB:
Sending Facility:	Sex: