



# Refugee Health Assessment Outcome Report

(Complete one form per family which did not receive an assessment)

Local Public Health Agency:	If refugee(s) moves to another county, please forward overseas medical records, copy of outcome report and 'pink' form, if applicable  <input type="checkbox"/> check box if forwarded to new county
Contact Person:	
Phone:	
Date: ____/____/____	

*Please select only one outcome code per person*

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:	
					1= moved out of state (out of MN)	7= refused screening
					2= moved to another county	8= never arrived to MN
					3= moved to unknown destination	9= located but numerous attempts to schedule failed
					4= unable to locate due to invalid contact information	10= died before screening
					5= missed appt./no show	11= 2ndry Ref: no insurance
					6= was screened elsewhere/unable to obtain results	12 =2ndry Ref: completed out of state
						13=2ndry Ref: Notification after time limit
					<b>If Outcome is "1"</b> select one of these screening status codes for each	
					A = Screening not Started	
					B = Incomplete Screening, needs medical follow-up*	
					C = Completed Screening, needs <b>only</b> follow-up	
					D = Completed Screening, needs Civil Surgeon services	

*Additional Remarks: If Outcome is "1" and Status codes are "B-D", please attach the name and contact information of the clinic that initiated the refugee health assessment*

**Please include the family's forwarding address and phone#:**

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**Return this form with the original health assessment packet to:**

Refugee Health Program  
 Minnesota Department of Health  
 Freeman Office Building  
 P. O. Box 64975  
 St Paul, MN 55164-0975