



Georgia Department of Public Health
REFUGEE DOMESTIC HEALTH ASSESSMENT FORM/INVOICE
 To Be Completed By Health Providers

SECTION 1

1) Alien Number 2) Date Of Arrival 3) Port of Entry _____

4) Last Name: _____ 5) Sex 6) DOB

7) Country of Origin: _____ 8) County: _____

9) Sponsor 1: _____ 10) Sponsor 2: _____
 (Volag) (Volag)

Phone City: _____ Phone

11) I-94 Status: Refugee AM Immigrant Asylee Cuban/Haitian Parolee Victim of Human Trafficking

12) Previous Resettlement: Yes No From: _____

13) Class A or B: A B For: _____

SECTION 2

14) Initial Health Assessment Date: _____ 15) Where Screened: How will your clinic be reimbursed for this screening?

Final Health Assessment Date: _____ CHD CHC RMA Medicaid (*Children age 0-20 bill to Medicaid*)

Condition	Services Or Examination	Abnormal Result	Normal Result	Not Tested/ Declined	Follow-Up Recommended	Fee Schedule	Reimbursement Claimed
16) Tuberculosis	QFT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$80.00	\$
	Mantoux PPD	<input type="checkbox"/> _____mm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$68.00	
	Chest X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Bacteriology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
17) Hepatitis B	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$43.00	\$
	HBcAB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Anti HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
18) Stool	Ova	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$15.00	\$
	Parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Bacteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
19) Sexually Transmitted Diseases	GC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$30.00	\$
	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
20) Physical Assessment	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$57.00	\$
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Visual Acuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
21) Pregnancy	Pregnancy Test	POSITIVE <input type="checkbox"/>	NEGATIVE <input type="checkbox"/>	NOT TESTED <input type="checkbox"/>	<input type="checkbox"/>	\$8.00	\$
22) Immunizations (Age -Appropriate)	Td/Tdap *	ADMINISTERED		NOT NEEDED	<input type="checkbox"/>	\$8.00 Admin Fee for each vaccination highlighted with an (*).	\$
	DTAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	MMR *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Hib	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Hepatitis A *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Hepatitis B *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Varicella *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pneumonia *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
23) Lead (<16 years)	Lead Level: _____	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/>		
24) HIV	A. Opted-In?	<input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/>	\$18.00	Do Not Include HIV Test Results On This Form
	B. Opted-Out?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			

25) Authorizing Signature _____ Title _____ Date _____

Total Reimbursement Claimed \$

