REFUGEE MEDICAL SCREENING GUIDANCE FOR WISCONSIN PROVIDERS

Division of Family and Economic Support

Bureau of Refugee Programs

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Wisconsin Department of Children and Families

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Overview of Refugee Medical Screening (RMS)

Scope: This document covers the recommended components of the Refugee Medical Screening (RMS) for clinicians providing screening for recent refugee arrivals to Wisconsin.

New refugees ideally go through RMS within 30 days after they arrive in the United States (U.S.). This screening is a complete physical exam with an emphasis on communicable diseases. The screening is billed to Medicaid as a new patient exam, level 4 visit or well child exam. Prior to the screening, clinicians review overseas screening results (if available) to obtain basic information about the refugee's health and immunizations. The refugee's Resettlement Agency (RA) will coordinate this exam with the clinic that will be providing the RMS.

Logistics of RMS

The RMS can be done with two face-to-face visits or a visit to the laboratory (for a blood draw) followed by a face-to-face exam with a clinician.

In Wisconsin, the RMS should be done through:

- An approved provider in the RAs jurisdiction, OR
- A clinic that has a contract with the Wisconsin Department of Children and Families (DCF) Refugee Programs Section OR
- Another site in Wisconsin that has reviewed the process with the State Refugee Health Coordinator.

Resettlement Agencies (RAs)

The U.S. Department of State, Bureau of Population, Refugees, and Migration (PRM) has cooperative agreements with resettlement agencies (RAs) to deliver refugee reception and placement services. In addition, in 2023, the Department of State, in collaboration with the Department of Health and Human Services, created Welcome Corps, a new private sponsorship program. This enables private sponsor groups (PSGs) to assist refugees through the initial core services phase of the resettlement process.

All refugees will have either a sponsoring organization or group working with them upon arrival to Wisconsin. For most refugees arriving in Wisconsin, the local affiliates of national RAs are responsible for refugee resettlement throughout the state and assist refugees in achieving self-sufficiency. RA staff work with newly arriving refugees on issues such as employment, English-language training, health service referrals, and housing.

Both Welcome Corps PSGs and RAs must ensure refugees in Wisconsin are supported to complete RMS. They secure transportation for refugees

to travel to appointments related to the screening and assist in follow-up appointments as needed.

Purpose of RMS

While refugees undergo extensive medical screening before travel, RMS is important for successful resettlement. The overseas screening is designed to identify any medical conditions which may exclude a person from traveling to the U.S. In contrast, the domestic screening is intended to reduce any existing health-related barriers a refugee may encounter during their resettlement, while also protecting the health of their neighbors.

Wisconsin endorses the Center for Disease Control (CDC) guidance for RMS. CDC has developed evidence-based guidance to clinicians in conducting the routine domestic medical screening of newly arrived refugees. In addition to the CDC guidance, the Minnesota Department of Health (in partnership with CDC) has developed CareRef, an online interactive tool for clinicians throughout the United States, which customizes screening guidance for individual refugees based on age, sex, and country of origin. The recommendations put forth by CareRef for patients is based on the most current CDC Guidelines.

Before the RMS

All refugees receive a medical screening overseas prior to their travel to the U.S. The refugee carries a copy of the screening results with them to the U.S. At U.S. ports of entry, the information is copied and transmitted electronically to the jurisdiction in which they will resettle. Review of the overseas screening records prior to RMS is highly recommended. If the refugee does not bring this information to their RMS appointment or if the information is incomplete, providers can access the information either through the refugee's RA or by contacting the Department of Children and Families, Bureau of Refugee Programs to the attention of the State Refugee Health Coordinator:

- dcfrefugee@wisconsin.gov
- 608-422-6269

If needed, the State Refugee Health Coordinator can also approve clinic-level access to the CDC's Electronic Disease Notification (EDN) System. Contact Savitri Tsering directly for additional information: savitri.tsering1@wisconsin.gov.

Components of a Domestic RMS

Any board-certified health care provider can perform the RMS.

The RMS should include:

1) General medical exam including:
    a. Health history and physical examination
    b. Nutrition and growth assessment
    c. Dental, vision, and hearing exams
    d. Immunization review and update
    e. Reproductive assessment
2) General lab testing including:
    a. A complete blood count with differential and platelets
    b. Urinalysis
    c. Glucose and serum chemistries

    d. Cholesterol levels for adults
    e. Metabolic panel for infants
3) Mental health screening
4) Lead testing (all refugee infants and children through the age of 16)
5) Malaria screening (if history or symptoms warrant)
6) Intestinal parasites screening and/or presumptive treatment
7) Sexually transmitted diseases screening, including:
    a. Syphilis
    b. Chlamydia
    c. Gonorrhea
8) HIV infection screening
9) Hepatitis B screening and vaccination
10) Hepatitis C screening (if indicated)

After the RMS

After Visit Summary

It is important that clinics print out the "After Visit Summary" document upon completion of a patient's health screening. This document provides medical advice and information on health concerns that were identified. It also lists any referrals needed for the refugee. After confirming a release of information is on file for the individuals, a copy should not only be provided to the patient as well as their RA or PSG health liaison.

Reportable Conditions

Wisconsin law requires that physicians, health care facilities, and laboratories report communicable diseases to the local health departments within 24-72 hours - depending on the disease category. Components of the RMS that are reportable to the patient's local/tribal health department (LTHD) include cases of: tuberculosis, latent tuberculosis infection, lead poisoning/exposure, COVID-19, malaria, syphilis, chancroid, chlamydia, gonorrhea, hepatitis B, and hepatitis C. HIV infection should be confidentially reported directly to the Wisconsin HIV Surveillance Team. Wisconsin law requires that physicians, health care facilities, and laboratories report communicable diseases to the local health departments within 24–72 hours - depending on the disease category. Components of the RMS that are reportable to the patient's local/tribal health department (LTHD) include cases of: tuberculosis, latent tuberculosis infection, lead poisoning/exposure, COVID-19, malaria, syphilis, chancroid, chlamydia, gonorrhea, hepatitis B, and hepatitis C. HIV infection should be confidentially reported directly to the Wisconsin HIV Surveillance Team.

Reimbursement

The RMS is billable to Medicaid. If a refugee is not eligible for BadgerCare (Wisconsin's Medicaid) they could qualify for Refugee Medical Assistance (RMA) for the first twelve months after they have been admitted to the U.S. In case of asylees and other eligible individuals, they could qualify for RMA after they have been granted asylum or another eligible status.

The Wisconsin Department of Health Services (DHS) partners with counties and tribes to help you apply for or enroll in programs such as:

- BadgerCare Plus
- Medicaid

- FoodShare

These county agencies are called income maintenance or economic support agencies. RMA can be applied for through local Wisconsin Works (W-2) agencies.

Special Considerations

Many refugees have not had age-appropriate screening for chronic diseases such as heart disease, diabetes, cancer, hearing, vision, or dental problems. These needs should be addressed in early follow-up visits. Several cancers are more prevalent in migrant populations, such as cervical, liver, stomach, and nasopharyngeal cancers. Introduce refugees to age-appropriate cancer screening tests, such as mammography, colonoscopy, and Papanicolaou tests during the RMS.

Integrate mental health screening into the RMS. Providers should screen for acute risk factors and triage refugees in need of urgent mental health treatment.

Mental health screening is to identify and evaluate refugees in need of mental health support and assistance. It is not designed to diagnose mental health conditions, but rather to identify individuals who should be referred for appropriate mental health diagnosis and management. Prompt referrals to mental health services may assist refugees in the resettlement process.

Respect a refugee patient's cultural and religious beliefs during the RMS, accommodating them as much as possible. For example, providers should honor their patients' preferred physician and interpreter gender when possible. Interpreters of the opposite gender from the patient may need to stand behind a curtain or screen. In some instances, the patient may not speak freely in front of an interpreter or provider of a different gender.

Special Considerations – Children

When examining refugee children, it is important for providers to remember they will have similar fears and anxieties as their U.S. counterparts. Furthermore, refugee children are at a high risk for developmental delay and behavioral issues. The provider should attempt to include a standardized developmental stage assessment in the RMS. Refugee children have high prevalence of malnutrition and growth delays. A standardized growth chart should be used by providers to determine whether a referral to the Women, Infant and Children (WIC) program, and other nutritional support, is needed.

Many refugee (adults and) children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred. Traumatic events can occur while they are in their country of origin, in their host country or during the resettlement process here in the U.S.

The Domestic RMS Checklist

General Medical Examination

Review of Systems

Review: constitutional symptoms, eyes, ears, nose, mouth, throat, cardiovascular, respiratory, gastrointestinal, genitourinary, gynecologic, musculoskeletal, skin, neurological, mental health, endocrine, hematologic, lymphatic, allergic/immunologic.

Physical Exam

General

- Examine: ears, nose, mouth, throat, neck, cardiovascular, respiratory, back, breasts, genitourinary, external genital exam, abdomen, extremities, musculoskeletal, skin, gastrointestinal, neurological.

Nutrition and Growth

- Take dietary history (e.g., restrictions, cultural dietary norms, etc.).
- Collect anthropometric indices, including weight, height, and, for young children, head circumference.
- Recommend therapeutic vitamins if any nutritional deficiencies are identified.

Dental

- Preform a basic dental screening.
    - Looking for obvious cavities, open sores, fillings/sealants, or reported oral pain.
- Apply (or refer patient for application of) topical fluoride for infants and toddlers and dental sealant for children with erupted 6- and 12-year molars. Wisconsin Medicaid recommends that children under age 5 who have erupted teeth receive topical fluoride treatment.

Vision and Hearing

- Perform a basic vision screening.
- Perform a basic hearing screening.

Reproductive Assessment

- Perform a pregnancy test if clinically indicated prior to administration of any vaccines or medications which may present a risk.
- Recommend prenatal vitamins and provide a referral for services if pregnant.

Immunizations

- Record previous vaccines, lab evidence of immunity, or history of disease.
    - Much of this information should be provided in the overseas medical examination paperwork.

- Give age-appropriate vaccines as indicated.
    - Complete any series that has been initiated. Do not restart a vaccine series.
    - Doses are valid if given according to accepted ACIP schedule.
    - **If a patient has no documentation, assume they are not vaccinated.**
    - Laboratory evidence of immunity may be an acceptable alternative for some immunizations.
- Offer age-appropriate, ACIP (Advisory Committee on Immunization Practices) recommended immunizations in accordance with Wisconsin school enrollment requirements.
- Provide additional immunizations, as identified by local public health, to address specific populations and health needs.
- Appointments for routine vaccinations are helpful in establishing and ensuring longitudinal primary care services for refugees.

Mental Health

Screening is to determine who should be referred for mental health diagnosis and management. Major Depressive Disorder, Posttraumatic Stress Disorder (PTSD), anxiety and adjustment disorders, and substance abuse are the most common mental health diagnoses seen among refugees. The key steps in conducting the domestic mental health screening are outlined below:

- Review overseas records for documentation of:
    - type and severity of any trauma/abuse
    - physical and mental disorders with associated harmful behaviors
    - substance-related disorders
- Ask directly about symptomology, functionality, and suicidal ideation as part of an integrated history and physical examination, helping to minimize stigmatization.
    - Note symptoms classically associated with mental health problems such as insomnia, changes in appetite and eating behaviors, nightmares, muscle tension, headaches, and/or diffuse body pain with no known etiology.
    - Mental health is generally stigmatized, and the patient may be more receptive to questions if they are posed as part of the individual's overall health rather than as an isolated or focused "mental" or "psychiatric" intensive interview.
- Conduct a mental health screening which could include:
    - Refugee Health Screener-15 (RHS-15)
    - WE-Check: Minnesota Wellness and Emotions Check
    - Patient Health Questionnaires PHQ-2 and PHQ-9
    - Specific questions developed by your clinic that assess mental health.
    - For children and adolescents (< 18 years of age), screen with a structured or semi-structured assessment, integrated into the overall health assessment.
- Consider asking the following throughout the examination:
    - Have you experienced trouble sleeping? Have you experienced any nightmares?
    - Have you experienced any change in your energy level?
    - Have you experienced any unexplained somatic symptoms (headaches, stomach aches, or back pain)?
    - Have you had any change in your appetite? Weight?

- **If these questions raise mental health concerns, ask:**
    - Do you have thoughts of harming yourself or hurting others?
    - Are you willing or interested in speaking with a mental health professional?
    - Refer to a professional for follow-up, as indicated.
- Look for the following throughout the examination:
    - Overseas medical record indicating diagnosis of mental illness
    - Physical signs of maltreatment
    - Patient becomes unusually anxious or agitated during the physical exam.
- Screen for substance abuse and educate about possible legal consequences of these behaviors in the United States. Make appropriate referrals if refugee is interested, and services are available. Interested refugees should also be connected with community resources and support groups.
- For those in need of mental health support and assistance, develop an impairment-related action plan with associated management and/or referral.

Laboratory Testing

General Laboratory Testing (recommended for all refugees)

- Perform complete blood count with differential and platelets.
- Conduct urinalysis (optional in persons unable to provide a clean-catch specimen).
- Perform glucose and serum chemistry tests.
- Conduct a cholesterol test (for adults).
- For Infants: Conduct infant metabolic screening, according to state guidance.

Disease-Specific Laboratory Testing

Tuberculosis (TB)

- Review overseas records for a Class B classification, indicating further follow-up
- Evaluate for signs or symptoms of disease or a history of close contact to someone with infectious TB.
- For children aged 2–14 years:
    - If Interferon Gamma Release Assay (IGRA) was negative overseas (within the last 6 months), and there are no signs or symptoms of TB disease upon physical examination, no further domestic evaluation is needed.
    - If the overseas IGRA was negative but performed ≥6 months prior to the domestic examination, repeat IGRA.

    - Treatment for latent tuberculosis infection (LTBI) should be considered after TB disease is ruled out for those with positive IGRA results unless TB disease or LTBI treatment was completed prior to arrival.
- For children aged <2 years, a tuberculin skin test (TST) is recommended (if not previously treated for LTBI or TB disease).
- For refugees aged ≥15 years:
    - If IGRA was not done overseas or a negative IGRA was documented >6 months prior, an IGRA is recommended at the domestic examination.
    - If overseas or domestic IGRA is positive, LTBI treatment should be considered after TB disease is ruled out (if not previously treated for LTBI or TB disease).
- Any refugee, regardless of country of origin, with signs or symptoms of TB disease should undergo clinical evaluation for TB disease.
- In the case of a positive TST or IGRA, perform a chest x-ray and sputum testing, as indicated (TST: What's Next, IGRA: What's Next).
- **Both TB and Latent Tuberculosis Infection (LTBI) are reportable conditions; report to the patient's LTHD within 24 or 72 hours respectively.**
- After reporting suspected or confirmed TB or LTBI, send the appropriate, completed form (LTBI, TB) to the Wisconsin Department of Health Services Tuberculosis Program.
- If TB or LTBI are diagnosed, refer the patient for follow-up or recommend initiation of indicated treatment (LTBI, TB).

Lead

- Perform an initial lead test on:
    - All refugee children and infants through 16 years of age.
    - Refugees > 16 years of age if there is a high index of suspicion, or clinical signs/symptoms of lead exposure.
    - Anyone who is pregnant or lactating **All newly arrived pregnant or breastfeeding women should be prescribed a prenatal or multivitamin with adequate iron and calcium.*
- Conduct an additional lead test on all children infant to 6 years of age within 3—6 months of placement in a permanent residence, regardless of initial lead test result.
- **All blood lead test results are required to be reported to Wisconsin Department of Health Services as lead poisoning/exposure is a reportable condition (within 48 hours). State Statute 181.04.**
- After reporting a case of lead poisoning/exposure to the LTHD, send the appropriate, completed form to the Wisconsin Department of Health Services.

Malaria

- **Note:** All sub-Saharan African (SSA) refugees who arrived from countries that are endemic for *Plasmodium falciparum* and who do not have a contraindication should be assumed to have received pre-departure presumptive antimalarial therapy with artemisinin-based combination therapy (ACT) and do not need further evaluation or treatment for malaria unless they have signs or symptoms of disease.

- Perform post-arrival testing or presumptive treatment for the following:
    - SSA refugees receiving **no** presumptive treatment prior to departure. This includes any women in their first trimester of pregnancy, or infants weighing less than 5 kg at the time of departure, for whom presumptive treatment is contraindicated.
    - Any refugee from a malaria-endemic country with signs or symptoms of infection.
- Refugees **not** requiring post-arrival testing or presumptive treatment include SSA refugees who received presumptive treatment prior to departure and all non-symptomatic refugees from malaria endemic countries outside SSA.
- **Malaria cases are reportable (within 72 hours) to the patient's LTHD.**
- After reporting a case of malaria to the LTHD, send the appropriate, completed form to the **patient's LTHD.**

Intestinal and Tissue Invasive Parasites (ITIP)

- Post-arrival screening for invasive parasites (IP) will depend on the region of departure and pre-departure presumptive therapy received
- Currently, all refugees without contraindications from the Middle East, South and Southeast Asia, and Africa receive a single dose of albendazole prior to departure. In addition, all SSA refugees without contraindications receive treatment with praziquantel for schistosomiasis.
- Most refugee children weighing more than 15 kilograms receive presumptive treatment with ivermectin before resettlement, unless contraindicated. Children weighing 15 kg or less have a lower likelihood of infection and therefore do not receive presumptive treatment.
- Perform ITIP screening in the following ways:
    - For all refugees regardless of their pre-departure treatment status:
        - Do an absolute eosinophil count (routinely recommended as part of the hematology testing and is not sensitive or specific for invasive parasites; however, a persistently elevated count indicates the need for further investigation).
    - For refugees who received incomplete presumptive therapy:
        - Provide the above in addition to:
            - Strongyloides (all refugees): Provide presumptive therapy or conduct diagnostics for Strongyloides (e.g., serologies for Strongyloides, two or more stool ova and parasites examinations, and/or Strongyloides culture/agar method).
            - Schistosomiasis: Provide presumptive therapy or conduct serologies for schistosomiasis.
    - For refugees who had no pre-departure presumptive treatment:
        - Provide the above in addition to:
            - Roundworms/nematodes (all refugees): Conduct stool ova and parasites examination (two or more samples) or provide presumptive treatment.

Sexual and Reproductive Health

- Syphilis
    - If no documentation, obtain treponemal testing (example, Syph IGG or TP-EIA) for the following:
        - All refugees 18 – 45
        - Refugees >45 if there is reason to suspect infection
        - Refugees younger than 18 who are at risk for congenital syphilis (i.e., mother who tests positive for syphilis, if the mother's syphilis results are not available, or the child is unaccompanied), who disclose sexual activity, or have been sexually assaulted.
    - Conduct a treponemal test to confirm any positive nontreponemal test
    - **Syphilis cases are reportable (within 72 hours) to the patient's LTHD.**
    - After reporting a case of syphilis to the LTHD, send the appropriate, completed form to the LTHD for further follow-up.
- Chlamydia
    - Conduct a urine nucleic amplification test for the following:
        - All refugees 18-24 who do not have documentation of pre-departure testing.
        - All refugees <18 or >24 must be tested if there is reason to suspect infection, or if there are risk factors, such as a new sex partner or multiple sex partners, sex partner with concurrent partners, or sex partner who has a sexually transmitted infection.
        - Women or children with history of or at risk for sexual assault, abnormal vaginal or rectal discharge, intermenstrual vaginal bleeding, or lower abdominal or pelvic pain.
    - Conduct a urine, rectal or pharyngeal (based on reported sexual history) nucleic amplification test for the following:
        - Men who have sex with other men
        - Male refugees with urethral discharge, dysuria, or rectal pain or discharge.
    - **Chlamydia cases are reportable (within 72 hours) to the patient's LTHD**
    - After reporting a case of chlamydia to the LTHD, send the appropriate, completed form to the LTHD for further follow-up.
- Gonorrhea
    - Conduct a urine nucleic amplification test for the following:
        - Leucoesterase (LE) positive on urine sample.
        - Women or children with history of or at risk for sexual assault.
        - Any refugee with symptoms.
    - Conduct a urine, rectal or pharyngeal (based on reported sexual history) nucleic amplification test for the following:
        - Men who have sex with other men
    - **Gonorrhea cases are reportable (within 72 hours) to the patient's LTHD.**
    - After reporting a case of Gonorrhea to the LTHD, send the appropriate, completed form to the LTHD for further follow-up.
- Screen for other STDs if the patient is symptomatic or has had a possible exposure.
- Female Genital Mutilation/Cutting

- Screen women and girls from countries where female genital mutilation/cutting (FGM/C) is practiced (UNICEF Data: Female Genital Mutilation (FGM): https://data.unicef.org/topic/%20child-protection/female-genital-mutilation/) for possible FGM/C-associated medical complications, including chronic pain and recurrent urinary tract infections.
- When discussing FGM/C with patients, it is critical that clinicians employ a non-judgmental, straightforward approach. Clinicians should mirror the language used by the patient.

HIV

- As of January 4, 2010, refugees are no longer tested for HIV infection prior to arrival in the United States
- Routine screening for HIV, ages 13- 64 years. Screening those <13 and ≥ 65 is also encouraged. Children <13 should be screened unless mother has negative HIV status and child is otherwise at low risk.
  - In most situations, complete risk information will not be available; thus, most children 12 and under should be screened.
  - For children <18 months of age, who test positive for HIV antibodies, test with DNA or RNA assays. Results of positive antibody tests in this age group can be unreliable because they may detect persistent maternal antibodies.
  - 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.
  - Screen all pregnant refugee women as part of their routine post arrival and prenatal medical screening and care.
- Refugees should be clearly informed orally or in writing that they will be tested for HIV.
  - If the refugee declines HIV testing, clearly document it in their medical record.
- Repeat screening 3—6 months following resettlement for refugees who had recent exposure or are at a high risk.
- 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.
- Provide culturally sensitive and appropriate counseling for all HIV-infected refugees in their primary spoken language and ensure the competence of interpreters and bilingual staff to provide language assistance for these patients.
- Refer all refugees confirmed to be HIV-infected for care, treatment, and preventive services.
- **Cases of HIV infection are reportable (within 72 hours by phone) to the state HIV Surveillance Team.**
- After reporting a case of HIV infection to the surveillance team, send the appropriate, completed form to the Wisconsin Bureau of Communicable Diseases Epidemiologist.

Hepatitis B

- New arrivals from certain countries may have been tested for hepatitis B surface antigen (HBsAg) and received one to two doses of the hepatitis B vaccine overseas through the Vaccination Program for US-bound Refugees. Domestic clinicians should review the DS-3025 (Vaccination Documentation Worksheet).
- Screen all new arrivals (≥18 years of age) for surface antigens (HBsAg), surface antibodies (anti-HBs), anti-HBc and IgM anti-HBc.
- Individuals who are hepatitis B surface antigen (HBsAg) positive should be screened for hepatitis D virus (HDV) in accordance with national recommendations.
- Refer all carriers (HBsAg positive) for additional medical evaluation.
- Test all pregnant refugees during each pregnancy, preferably in the first trimester, regardless of vaccination status or testing history.
- All refugees < 18 years of age should be tested for HBsAg – if not previously tested and they have an incomplete vaccination history.
- **Hepatitis B cases are reportable (within 72 hours) to the patient's LTHD.**
- After reporting a case of Hepatitis B to the LTHD, send the appropriate, completed form to the LTHD for further follow-up.
- Vaccinate all arrivals who are negative for all HBV markers. Patients testing positive for anti-HBs are immune and no vaccine is needed.

Hepatitis C

- Universal hepatitis C virus (HCV) screening for all new adult arrivals (>18 years of age).
- Hepatitis C screening is recommended for all pregnant persons during each pregnancy.
- Hepatitis C screening is not routinely recommended for children <18 years of age but is recommended for unaccompanied refugee minors.
- Testing is recommended for children born to HCV-positive mothers and should be tested using HCV RNA test after 2 months of age.
- **Hepatitis C cases are a category II reportable disease and must be reported within 72 hours either electronically through the Wisconsin Electronic Disease Surveillance System (WEDSS), by mail or fax using Acute and Communicable Disease Case Report, F-44151.**
    - Most disease reports are now received electronically through the Wisconsin Disease Surveillance System (WEDSS). Healthcare providers and laboratories can register to report electronically through WEDSS https://www.dhs.wisconsin.gov/wiphin/wedss.htm.

Resources

- Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees
- Minnesota Refugee Assessment Form
- Office of Refugee Resettlement Domestic Medical Screening Guidance Checklist

The Department of Children and Families is an equal opportunity employer and service provider. If you have a disability and need to access services, receive information in an alternate format, or need information translated to another language, please call the [PROGRAM AREA or DIVISION at NUMBER]. Individuals who are deaf, hard of hearing, deaf-blind or speech disabled can use the free Wisconsin Relay Service (WRS) – 711 to contact the department.