



Guidelines for Pediatric Immigrant Health

Future of Pediatrics 2015

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Learning Objectives

- Distinguish the various legal statuses of immigrant children.
- Formulate a care plan for an office-based visit of a newly-arrived immigrant pediatric patient.
- Identify community resources for your immigrant patients with needs beyond your office's resources.

**It's a busy Wednesday in clinic.
You open the door to the next exam room to see:**





Child here via legal immigration



Child with illegally-arrived parent



Unaccompanied child

IMMIGRANT CHILD?

Trafficked child



Refugee child



So let's define immigrant status:

Who is an immigrant?

- **Citizen** – Born in the US or born abroad to a US citizen
- **Naturalized Citizen** – Applied for, and was granted, citizenship after having been a lawful permanent resident (LPR) for 5 years
- **Lawful permanent resident (LPR)**– Has the right to live and work permanently in the US. May apply for citizenship after 5 years. Has a green card.
- **Refugee** – Persecuted in home country because of race, religion, nationality, political opinion, etc. Applied for, and was granted, status while OUTSIDE the US. May apply for LPR status 1 year after entering the US.

Who is an immigrant?

- **Asylee** -Persecuted in home country because of race, religion, nationality, political opinion, etc. Applied for, and was granted, status while INSIDE the US. May apply for LPR status 1 year after entering the US.
- **Undocumented/Unauthorized** – Entered the US without inspection by US Immigration, or once had legal status but it has expired or been terminated.
- **Immigrant children**- children who are foreign-born OR children born in the U.S. who live with at least 1 parent who is foreign-born. (AAP Policy statement in Pediatrics: June 2013)

Who is an unaccompanied minor?

- No lawful immigration status in the United States
- < 18 years of age
- No parent or legal guardian in the United States

(or no guardian in US able to provide care and custody)

Administration for Children and Families, 6 U.S.C. § 279(g)(2).

- Care and custody of unaccompanied minors now under Health and Human Services:
 - Goal to be “promptly placed in the least restrictive setting that is in the best interest of the child.”

8 U.S.C. § 1232(b)(2)

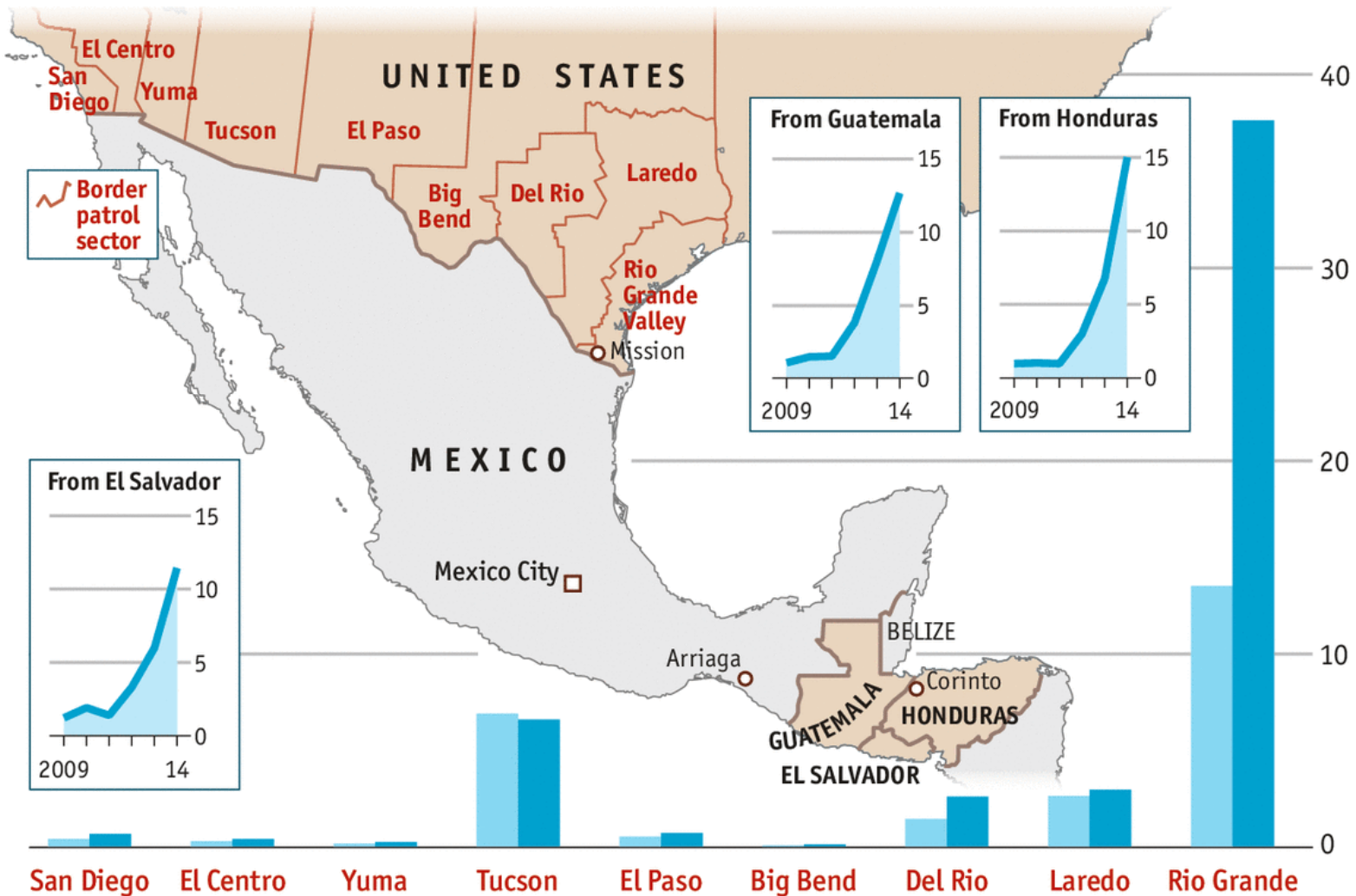
Where are children in our region coming from?

The surge from Central America

Unaccompanied children* caught crossing the US-Mexico border, '000

Fiscal years ending September 30th

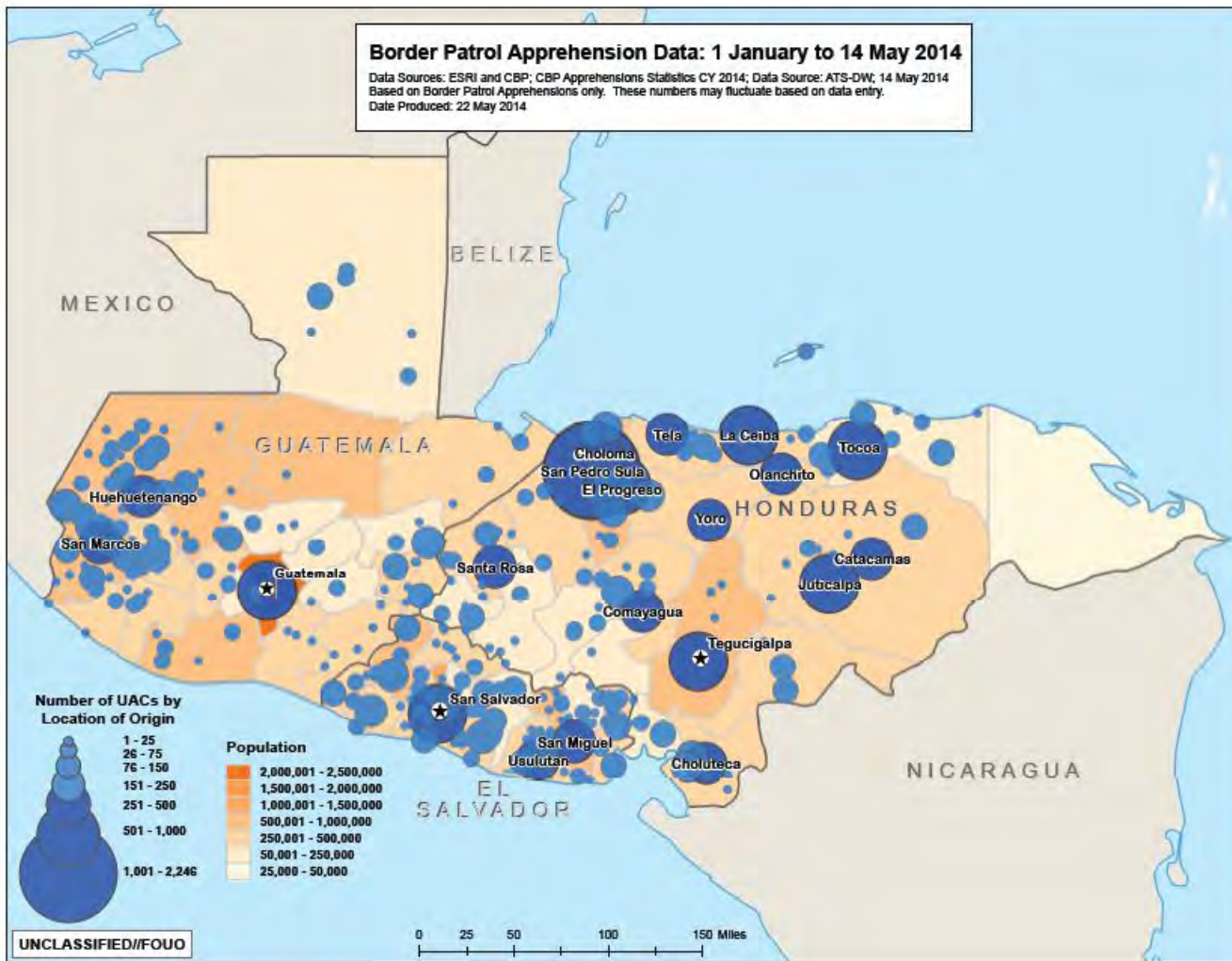
2013† 2014†



Source: US Customs and Border Protection

*Under 17-year-olds †October 1st-June 15th

Where are children in our region coming from?



- Guatemala (37%)
- El Salvador (26%)
- Honduras (30%)
- Mexico (3%)
- Ecuador (2%)
- Other (3%)

-updated May 2014
 Office of Refugee
 Resettlement

Children and Immigration

- Immigrant children:
 - Fastest growing segment of US population
 - Accounted for most of pediatric population growth in 2000s
- 1 in every 4 children in US lives in an immigrant family (18.4 million children)
- 89% of these children are born in the U.S. and are U.S. citizens.

MCPS MD: Changing Enrollment

MCPS Enrollment %	1984	2014
White	71.3	31
African-American	14.5	21.5
Hispanic	5.2	28.5
Asian	8.7	14.2

Washington Post 10/03/2014



DC Immigration Data:

- Total population 2014 estimate: 658,893
- Percent change April 2010 to July 2014: **9.5%**
- Persons under 18 years: 17.2%
- Foreign-born persons, 2009-2013: **13.8%**
- Since 1990 has increased **35%**
- Annual rate of increase in foreign-born population of **3,000 people.**

- 1 in 8 Washingtonians are Latino or Asian
- US Census Bureau:
 - The **Latino share of Washington, D.C.'s population** grew from 5.4% in 1990, to 7.9% in 2000, to 9.5% (or 58,744 people) in 2011.
 - The **Asian share of the population** grew from 1.8% in 1990, to 2.7% in 2000, to 3.6% (or 22,510 people) in 2011.

Latinos and DC

- 9.1% of DC population is Latino (2011)
- Latinos are the fastest growing ethnic minority in DC
- 46.3% live in Ward 1
 - Mt Pleasant, Adams Morgan, Columbia Heights
- Many Salvadorans initially arrived as asylees after the Salvadoran Civil War (1979-1992)
 - Political violence
 - Deteriorating economy



Africans and DC

- 1 in 10 African-born immigrants to the US live in the DC Metro area
- Washington Metro has proportionally the largest African-born population of all US cities
- African immigrants make up 11% of total DC immigrant population
- Ethiopia, Nigeria, Egypt, and Ghana have the largest communities in DC

Africa



DC Safety Net: Immigrant Children's Program

- Eligibility:
 - < age 21
 - School attendance not required
 - No citizenship requirement but must be DC resident
 - Not eligible for Medicaid
 - Income < 200% Federal Poverty Level (\$47,700 family of 4)
- Once child is eligible: automatically assigned to managed care plan:
 - AmeriHealth DC, MedStar Family Choice, Trusted Health Plan, HSCSN
- Services: identical to services covered under Medicaid:
 - Primary medical care visits, eye care, preventive care (checkups, diet and nutrition), dental services, prescription drugs, laboratory services, medical supplies

Approach to Caring for Immigrant Children

- How are immigrant children different from those born in US?
 - Clinical issues
 - Mental health issues
 - Social issues
 - Current guidelines and limitations

Clinical Issues

Clinical Issues

- **CASE:**
- 12 year old boy new to the office comes in for a physical. He is with his mother and is from Mexico. He has no complaints and per the mom is healthy with no past medical problems. On the PE you note that he can not open his mouth more than a few centimeters. His jaw is non-tender.

Clinical Issues

- **CASE- Continued**
- Patient had fallen out of a tree many years ago and hit his jaw. He never saw a doctor in Mexico but reports that he had a lot of pain and swelling at the time. He can eat ok but will have some pain eating very hard things.
- Lack of access to care in many countries creates difficult to manage cases
- Chronic diseases such as asthma, seizures, and growth problems go unchecked
- Injuries are often untreated
- Scars

Clinical Issues

- Growth
- Infectious diseases
- Environment: Ingestions/Toxins
- Development
- Vaccinations

Clinical Issues: Growth

- Malnutrition: stunting and physical growth delay
- Short stature and growth problems
 - Chronic intestinal infections
 - Lack of nutritious foods
 - Anemia
 - Chronic Diseases
- CDC Growth Charts not developed on samples of immigrant children
- Significant catch-up growth in 1st year –follow closely
- Chronic diseases not followed

Clinical Issues: ID

- TB
- Parasitic infections:
 - Giardia intestinalis
 - Ascaris lumbricoides
 - Trichuris trichura
 - Opisthorchis
 - Taenia solium
 - Entamoeba histolytica
 - Hookworm
 - Strongyloides
 - Cryptosporidium
 - Cysticercosis
 - Schistosomiasis
- HIV 1, 2
- Syphilis
- Malaria
- Viral hepatitis:
 - Hepatitis A
 - Hepatitis B
 - Hepatitis C (esp Russia, Eastern Europe, Egypt, or China),
 - Hepatitis D
- Typhoid among recently arrived febrile patients
- Region-specific infections:
 - Chagas disease
 - coccidioidomycosis
 - histoplasmosis
 - *Trypanosoma cruzi*
 - Lymphatic filariasis
- *Helicobacter pylori*
- Skin infections
 - Scabies
 - Lice
 - Impetigo

Clinical Issues: Environment/Toxins

- Toxic and Environmental Exposures:
 - Lead exposure: before arrival or after relocation to older homes
 - Cooking practices: containers contaminated with lead or copper
 - Prenatal exposure to alcohol: FAS
 - Environmental pollutants: Radioactivity and pesticides
 - Workplace injuries/transportation injuries common for migrant children

Clinical Issues: Developmental Delay

- High rates of speech and language delay
 - Lack of early education
 - Lack of books
 - Lack of appropriate stimulation
 - Illiteracy
- Denver Developmental Survey
 - “What is a curtain?”
 - Not necessarily appropriate for an immigrant community
- School-Aged kids
 - ESL/ELL Services
 - IEP
 - Psychoeducational Evaluations

Clinical Issues: Vaccinations

- Many immigrant children will have received some vaccines in their country
- In the Latino community, vaccinations are VERY important and families rarely refuse or question vaccinations
- We have access to many more vaccines than other countries
- Know the vaccine practices of the countries your patients are from: WHO and CDC Websites: CDC Pinkbook
- Recommendation is to repeat series rather than draw titers (cheaper, little risk of harm)

Clinical Issues: Vaccinations

- Vaccines administered outside the United States can generally be accepted as valid if the schedule was similar to that recommended in the United States
- Only **written documentation** should be accepted as evidence of previous vaccination. Check dates carefully as other countries may have different vaccine schedules.
- If there is no vaccine card, or you can not read the date of a vaccine, recommendation is to **repeat series** rather than draw titers (cheaper, little risk of harm)

Spanish	
Cólera	Cholera
Coqueluche	Pertussis
Difteria	Diphtheria
Doble Antigen	Td (Mexico)
Doble Viral	Measles-Rubella (Mexico)
Duple	DT (Cuba)
Gripe	Influenza
Hemófilo tipo b	Hib
Numonía	Pneumonia
Paperas, Parotiditis	Mumps
Poliomielitis	Polio
Pulmonía	Pneumonia
Rubéola	Rubella
Sarampión, Sarampión Comun	Measles
Sarampión Aleman	Rubella
SPR	MMR
Tetánica, Tétano	Tetanus
Tos Ferina	Pertussis
Varicela	Varicella
Viruela	Smallpox
Ethiopian (Oromiffaa)	
Cufaa	Tetanus
Difteeriyaa	Diphtheria
Gifira	Measles
Gifira farangli	Rubella
Laamsheesaa	Polio
Qakkee	Pertussis
Shimbiraa	Hepatitis

- Resource: CDC PinkBook

Mental Health Issues

Mental Health Issues

CASE

16 y.o. girl from El Salvador comes to the clinic for her first appointment. She has been in the US for 2 months and has gained 10 lbs since she arrived. She is living with her mother, her mother's boyfriend and their 12 mos old and 3 year old boys. The patient's mother has been in the US for 7 years. The patient lived with her grandmother in El Salvador. The mom does not know anything about her PMH, medication, Allergies, etc. You rely on the patient's history as her grandmother is in El Salvador.

Mental Health Issues

CASE- Continued

It is very apparent that the mother and daughter are not getting along. When you interview the daughter alone, she cries and tells you that she “hates” her mother and wishes she was back in E.S.

3 months later she comes back in for an appt and she is pregnant.

Mental Health Issues: Reuniting

- Many parents leave their children behind when they first come to the US
- They send money back to their home countries to support their children
- Reuniting with their children is often bitter-sweet
- Food used to connect/relieve guilt; stressed patients may overeat or undereat
- Many teens end up looking to their peer groups for support and engage in high risk behavior

Mental Health Issues

- Posttraumatic Stress Disorder, domestic violence:
 - Witnessing violence at home, in country of origin, or on trip to US.
 - Parallel with screening children born in US for home violence, intimate partner violence
 - Fear of ICE/anxiety about family separation
- Acculturation, Adjustment disorders: joining new family group, new culture- culture shock
- Depression
- Anxiety
- Substance abuse

Mental Health Issues

- Next steps as a clinician
- Mental Health services for kids are very limited, especially in other languages (i.e. Arabic) and no insurance
- Find local community groups that support ethnic communities – LAYC, Ethiopian Community Center
- School Social Workers

Social issues

Social issues

- Social dimension:
 - Family structure disrupted if traveling with only part of family; reunification issues
 - School achievement and school absence
- Health literacy:
 - Understanding use of medical home
 - Understanding of medical system/access to care

- **CASE 1:**

12 y.o. girl who arrived from El Salvador 2 weeks ago presents to the office for a routine school physical. Her mother states that she has shortness of breath and chest pain with exercise. She states that she has a history of a “heart operation” that was done when she was about 8 years old but does not know why and has had no cardiac follow-up since then. Her PE reveals normal vital signs, no murmur, with a large sternal scar.

Social Issues: Access

- What do you do?
- Logistical Issues: Can the family obtain her records?
- Specialist referral? – Insurance, Language issues
- Sports clearance?
- How do you explain our medical system?

- **CASE- Continued**

- Your patient with a sternal scar returns to clinic and says she does not have insurance and the family can not afford to pay for a visit to the cardiologist.
- What do you do?

Social Issues- Insurance

- Immigrants and Medicaid
 - Immigrants who entered the US (lawfully) after 8/22/1996 were **barred from receiving Medicaid or CHIP coverage for 5 years, but with passage of CHIPRA in 2009 this was waived and now gives states the option to cover immigrant kids**
- Know your state

Social Issues- Insurance

- Patients need insurance for –
 - Referrals
 - Medications
 - Lab work
- Patients do not need insurance for –
 - Vaccines
- In DC: Refer to Immigrant Children's Program
 - If no clinic social worker, parent navigator may be able to help

Current Guidelines

- AAP Policy Statement (2013)
- AAP Toolkit
- CDC Guidelines (2012): Division of Global Migration and Quarantine. Summary Checklist for the Domestic Medical Examination for Newly Arriving Refugees. July 2012.
- AAP Red Book, 2006. Medical Evaluation of Internationally Adopted Children
- DC AAP Immigrant Health Committee: *in progress*

Limitations of guidelines

- AAP policy statement offers few clinical guidelines
- AAP toolkit also vague- leaves out specific recommendations for specific ages, evidence-based best test to order
- CDC guidelines are for all refugees/immigrants; not just pediatric population; leaves out vision/hearing/dental
- Adoptee guidelines most specific, but less coverage of social issues/mental health
- No guidelines are country or region-specific
- Mental health limited
- Connections to other community resources limited
- Patient experience will be different at different providers across country, even across DC area
 - Fragmented care: detention centers, outpatient clinics, EDs
 - No central recordkeeping/ vaccination registries not up to date
- New field: area not covered well in residency

CDC guidelines

- CDC. Division of Global Migration and Quarantine. Summary Checklist for the Domestic Medical Examination for Newly Arriving Refugees. July 2012.
 - (replaced the General and Optional Testing during the Domestic Medical Examination for Newly Arriving Refugees- Guidelines and Discussion available 2010)

CDC guidelines: general exam

- History and physical:
 - Specifically, history to include **mode of travel, border crossing, previous screening or vaccination**
- Nutrition and growth:
 - **Dietary history:** malnutrition vs. obesity, rickets, iodine deficiency
 - **Anthropometric indices:** weight, height, head circ
- Immunizations:
 - **Record previous vaccines** or history of disease
 - Doses valid if given according to accepted ACIP schedules

CDC guidelines: general labs recommended for all

- **CBC with diff:**

- Anemia: iron deficiency most common, also hemoglobinopathies or G6PD deficiency: esp African, Southeast Asian, Hispanic or Mediterranean background; also ID: malaria, intestinal parasitosis.
- Eosinophilia: most commonly parasitosis; also allergies/atopy or med reaction
- Thrombocytopenia: HIV or tropical infections causing hypersplenism

- **Lead:**

- Iron deficiency increases intestinal absorption of lead
- Screen all children 6 months-16 years
- Multivitamins for all children aged 6 months-6 years
- Repeat lead screen 3-6 months after placement in a new residence for ages 6 months-6 years.

CDC guidelines: general labs recommended for all

- **Newborn metabolic screening:**
 - MD/DC do not have maximum age for allowed sample
 - Note: CF screen less accurate after 2 months of age
- **Intestinal parasites:**
 - **O&P x 3** (if no pre-departure treatment)
 - **Stool giardia**

CDC guidelines: general labs recommended for all

- TB screening:
 - Evaluate for history of positive contacts, disease signs/symptoms
 - Age \geq 5 years:
 - CDC recommends **Quantiferon** blood test
 - Covered fully by Amerihealth
 - If positive, get CXR
 - CXR w/out evidence of active TB \rightarrow treat for LTBI
 - Age $<$ 5 years:
 - **Place PPD**
 - **wait 4 weeks after live virus vaccine to place PPD
 - Disregard BCG vaccination when reading PPD
 - If positive, get CXR

CDC guidelines: general labs recommended for all

- HIV screening:
 - As of Jan 2010: no longer mandatory testing for refugees
 - **Screen all refugees (Rapid 1,2 HIV); repeat in 3-6 months** after resettlement
 - Screen all pregnant refugee women
 - Children:
 - Screen children <12 unless mom's status confirmed negative and no history of exposure risk
 - Vs "...screening for HIV should be performed on all internationally adopted children." AAP Red Book, 2006. Medical Evaluation of Internationally Adopted Children – p186
 - Children <18 months with + HIV Ab: test with DNA/RNA assays
 - Chemoprophylactic Bactrim for all children >6 weeks of age, born to HIV + mom

CDC guidelines: general labs *to consider*

- Pregnancy test (consider)
 - Consider prior to live vaccines (MMR, rubella), live influenza, or HPV
 - If positive: Recommend prenatal vitamins, refer for services
- Urinalysis (consider if can provide clean-catch)
 - Helpful to detect renal diseases, systemic diseases (DM), STIs
- Basic metabolic panel (consider)
 - If indicated by signs/symptoms/comorbidities

CDC guidelines: general labs *to consider*

- STI screening:
 - **RPR**
 - all refugees ≥ 15 yo
 - Sexually active/history of abuse
 - Mother testing positive
 - Confirmation testing for + treponemal tests (other species: yaws)
 - **Urine Gonorrhea/Chlamydia:**
 - Women < 25 who are sexually active, history of abuse
 - Symptomatic refugee
 - LE positive on urine sample (marker for gonorrhea)

CDC guidelines: general labs *to consider (certain populations)*

- Hep B screening: endemic Hep B areas (Asia and Africa):
 - screen with HBsAg, Anti-HBsAg, Anti-HBCore
- Malaria: Sub-Saharan Africa endemic for *Plasmodium falciparum*:
 - PCR is most sensitive for sub-clinical malaria, then peripheral smear
- Schistosomiasis: Sub-Saharan Africa:
 - single dose praziquantal
- Intestinal and tissue invasive parasites (ITIP): Middle East, South & Southeast Asia, Africa:
 - Single dose albendazole
- H. pylori- in pts with microcytic anemias
 - Esp if abd pain and/or no response to iron
- Lipid profile

Pediatrics in Review:

International Adoptees (2008)

- Vaccination: Follow catch-up immunization schedule
- Hearing and vision screening
- Developmental testing: reassess every 3-4 months in 1st year
- Laboratory testing:
 - CBC
 - Lead
 - HepBSAg, anti-HepBSAg
 - Rapid 1,2 HIV
 - RPR
 - Stool O&P
 - Stool Giardia & Cryptosporidium
 - PPD regardless of BCG status
 - Hep C serologies (if endemic Hep C area)
 - NMS for infants

(From Red Book 2008)

Mental Health:

National Child Traumatic Stress Network

Stressors for refugees:

- Traumatic Stress; intense event causes harm to child's emotional and physical well-being
 - War and persecution
 - Displacement from their home
 - Flight and migration
 - Poverty
 - Family/community violence
- Resettlement Stress; children/families experience when building a new life:
 - Financial stressors
 - Difficulties finding adequate housing
 - Difficulties finding employment
 - Loss of community support
 - Lack of access to resources
 - Transportation difficulties

Mental Health:

National Child Traumatic Stress Network

Stressors for refugees:

- Acculturation Stress; children/families experience as they try to navigate between a new culture and their culture of origin:
 - Conflicts between children and parents over new and old cultural values
 - Conflicts with peers related to cultural misunderstandings
 - The necessity to translate for family members who are not fluent in English
 - Problems trying to fit in at school
 - Struggle to form an integrated identity including elements of their new culture and their culture of origin
- Isolation Stress; children/families experience as minorities in a new country:
 - Feelings of loneliness and loss of social support network
 - Discrimination
 - Experiences of harassment from peers, adults, or law enforcement
 - Experiences with others who do not trust the refugee child and family
 - Feelings of not “fitting in” with others
 - Loss of social status

Mental Health: National Child Traumatic Stress Network

- Core Stressors overview:



Mental Health: National Child Traumatic Stress Network

Screening assessment tool:
Trauma risk assessment

Refugee services toolkit:

[http://learn.nctsn.org/
course/view.php?id=62](http://learn.nctsn.org/course/view.php?id=62)

Level of Risk	
Low	<p>Child may experience occasional distress or trauma-related symptoms in response to reminders or other stressors such as:</p> <ul style="list-style-type: none">◊ Problems with emotion regulation◊ Problems with accessing social support◊ Continued environmental stressors <p>However the child is functioning well, symptoms do not interfere with functioning at home, school, or in social situations and child reports overall general good mood most days.</p>
Moderate	<p>Child reports some symptoms of emotional distress such as:</p> <ul style="list-style-type: none">◊ Depressed mood◊ Irritability◊ Trauma-related symptoms such as:<ul style="list-style-type: none">◊ Flashbacks,◊ Hypervigilance,◊ Trouble concentrating <p>Symptoms seem to be interfering with functioning at home, school, work, or in social relationships.</p>
High	<p>Child reports acute or severe symptoms of emotional distress or behavioral dysregulation including risky behaviors such as:</p> <ul style="list-style-type: none">◊ Self-injury◊ Suicidal ideation◊ Aggressive behavior <p>Child's symptoms are severely interfering with functioning at home, work, school, with peers; unable to attend school or develop appropriate social relationships; difficulties completing basic tasks, etc.</p>

Mental Health

- Refugee Health Screener-15 (RHS-15) for children ≥ 14 yo:
 - © 2011 Pathways to Wellness: Integrating Refugee Health and Well-being



SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

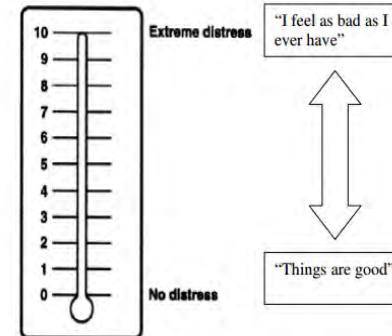
The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

10. Had the experience of reliving the trauma; acting or feeling as if it were happening again?	0	1	2	3	4
11. Been having PHYSICAL reactions (for example, break out in a sweat, heart beats fast) when reminded of the trauma?	0	1	2	3	4
12. Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?	0	1	2	3	4
13. Been jumpier, more easily startled (for example, when someone walks up behind you)?	0	1	2	3	4

14. Generally over your life, do you feel that you are:
- Able to handle (cope with) anything that comes your way0
 - Able to handle (cope with) most things that come your way1
 - Able to handle (cope with) some things, but not able to cope with other things.....2
 - Unable to cope with most things.....3
 - Unable to cope with anything4
- 15.

Distress Thermometer

FIRST: Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



ADD TOTAL SCORE OF ITEMS 1-14: ____

SCORING	
Screening is POSITIVE	
1. If Items 1-14 is ≥ 12 OR	Self administered: ____
2. Distress Thermometer is ≥ 5	Not self administered: ____
CIRCLE ONE: SCREEN NEGATIVE	SCREEN POSITIVE
	REFER FOR SERVICES

Mental Health: Assets/Resiliencies

- DC Public Schools: International Academy at Cardozo HS
 - <http://www.wusa9.com/story/news/local/2014/10/01/cardozo-high-school-dc-english-learning-community/16553403/>



Next steps

- Protecting Immigrant Children now a top priority for AAP
- Nov. 2014: AAP Board of Directors dedicated support through Tomorrow's Children Endowment (TCE)
 - Help recent immigrants settle and receive needed services
 - Identifying areas for multi-sector service partners to collaborate at the community level
 - Provide funding to support training workshops for MDs addressing mental health needs

Next steps

- Centralized guidelines
 - DC AAP Immigrant Health Committee is working to develop country-specific best practices for all providers seeing immigrant children
 - Projected go-live date: end of 2015

Next steps

- Know your immigrant community – each ethnic group has unique social and medical needs
- Build your team:
 - Social work
 - Community resources for immigrant children and families
- Never underestimate the strains on immigrant children and families
- Be curious– ask questions!
- No matter where you work: immigrants will be part of your practice!

SUMMARY SLIDE: GUIDELINES

History:

- Country of origin
- Migration route: mode of travel, border crossing, previous screening or vaccination
- Active health concerns
- Current legal guardian/housing
- School history: gaps, registered
- Dietary history
- Social/exposure history/trauma history
- Substance use history
- Sexual history
- Detention center: previous screening or vaccination

Immunizations history:

- Record previous vaccines

Exam:

- Anthropometric indices: weight, height, head circ
- Vision/hearing screening
- Dental screening/referral
- Full physical exam
- Mental health screening: Refugee Health Screener-15 or general MH screen

Labs:

- CBC with diff
- Lead; repeat in 3-6 months
- Newborn Metabolic Screen
- Stool studies: O&P x 3, stool giardia
- PPD if <5 years, Quantiferon if ≥ 5 years
- Rapid 1,2 HIV; repeat in 3-6 months

Labs to Consider:

- *Pregnancy test*
- *UA*
- *CMP*
- *Lipid profile*
- *RPR*
- *Urine gonorrhea/chlamydia*
- *Hep B/Hep C screening*
- *Malaria*
- *Schistosomiasis*
- *Intestinal and tissue invasive parasites (ITIP)*
- *H. pylori*

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