OFFICE USE ONLY	Client no.:	Date received: / /	Application no.:

May 2022

NEW ZEALAND IMMIGRATION

New Zealand Immigration Settlement Health Instructions (INZ 1263)

INFORMATION ABOUT THESE INSTRUCTIONS

The settlement health instructions provide:

- an overview of the settlement health service for United Nations High Commissioner for Refugees (UNHCR) – mandated refugees who have been approved for a New Zealand resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category
- an outline of your role and responsibilities within this service as a service provider
- information and guidelines to assist physicians to complete eMedical or paper settlement health forms
- a standardised process to obtain appropriate, accurate and comprehensive health information

The settlement health instructions explain the standard of practice required to complete Immigration New Zealand's (INZ) settlement health forms. The settlement health instructions **are not** a technical medical reference manual.

The settlement health service only applies after the UNHCR-mandated refugee has been approved for a New Zealand resident visa. Physicians should refer to the *New Zealand Panel Member Instructions (INZ 1216)* when completing immigration medical examinations as part of the visa decision process.

INTRODUCTION

Settlement Health Services

UNHCR-mandated refugees who have been approved for a New Zealand resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category are referred to as Humanitarian UNHCR visa holders. Settlement health services are part of INZ's resettlement services offered to Humanitarian UNHCR visa holders. Well-managed resettlement services, including health services, facilitate better outcomes for Humanitarian UNHCR visa holders and instil confidence in the receiving community in New Zealand.

INZ offers a settlement health service for Humanitarian UNHCR visa holders. While settlement health services are not mandatory for Humanitarian UNHCR visa holders, they are strongly recommended. INZ encourages settlement health service providers to establish a process by which all Humanitarian UNHCR visa holders are able to access, and are provided with, settlement health services.

INZ's settlement health checks and services are outlined in the four forms listed below:

eMedical examination name	Paper-format examination name	For examination requirements see:
948 Settlement health assessment	*Settlement Health Assessment (INZ 1260)*	Part 1 of these Instructions
956 Settlement Additional Information	*Settlement Additional Information (INZ 1364)*	Part 2 of these Instructions
953 Settlement Vaccinations	*Settlement Vaccinations (INZ 1251)*	Part 3 of these Instructions
949 Departure Health Check	*Departure Health Check (INZ 1262)*	Part 4 of these Instructions

INZ will update these settlement health instructions and INZ settlement health processes from time to time. Updated settlement health instructions can be found at: www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network. eMedical will always carry up-to-date forms. Up-to-date paper forms are available on the INZ website at www.immigration.govt.nz/new-zealand-visas/apply-for-a-visa/tools-and-information/forms-guides-and-checklists.

Glossary

Applicant – a person who applies to enter or remain in New Zealand as a permanent resident (including refugees who may be referred to as candidates) or as a temporary entrant (including tourists, students or temporary workers).

Candidate – a person mandated as a refugee by the UNHCR (the United Nations refugee agency) who has been selected as a candidate for New Zealand's Refugee Quota Programme.

Client - UNHCR-mandated refugees who have been approved for a New Zealand resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category.

Conditions – physical, mental, emotional or intellectual disorders of the client that are identified by either the client or by the physician from the history, assessment and subsequent tests.

Family group – where applicable, will include a principal client, his or her partner and their dependent children. In most cases, all of the family group will have been included within a single visa application.

Immigration instructions – these consist of immigration eligibility of a person for the grant of a visa; and any other relevant information that should be taken into account in assessing a person's eligibility for a visa. Immigration instructions are certified by the Minister of Immigration under section 22 of the Immigration Act 2009.

Immigration medical examination (IME) – the medical examination for INZ visa determination purposes that includes the functional inquiry for present, past, and family history, the findings on physical and mental examination and the results of all relevant radiology, laboratory and diagnostic tests including further specialist reports.

Incapable person – a person who is incapable of understanding the general nature, effect of, and purpose of the requirements for providing a signature. Such people may include those with an intellectual disability.

Medical certificates – INZ health forms used for determining if an applicant meets visa health requirements. Specifically, the *General Medical Certificate (INZ 1007) /501 Medical Examination, Limited Medical Certificate (INZ1201) / 512 Limited medical examination*, *Chest X-ray Certificate (INZ 1096) / 502 Chest x-ray examination* and *RSE Scheme Supplementary Medical Certificate (INZ 1143)*.

Refugee Health Liaison Team (RHLT) – a clinical team at INZ who support the health and wellbeing of New Zealand refugees throughout their journey and settlement in New Zealand.

Settlement health services – offshore health services available to approved UNHCR-mandated refugees. Services include a comprehensive health screening and assessment, vaccinations and a departure health check.

Settlement health forms – INZ health forms used to assess settlement health status for approved UNHCR-mandated refugees. Specifically, *Settlement Health Assessment (INZ 1260)*, and *Departure Health Check (INZ 1262)*.

Specialist report – a written document received from the relevant specialist that provide a complete record of the mental or physical condition being considered, including the history, findings on physical examination, diagnosis, current treatment and prognosis.

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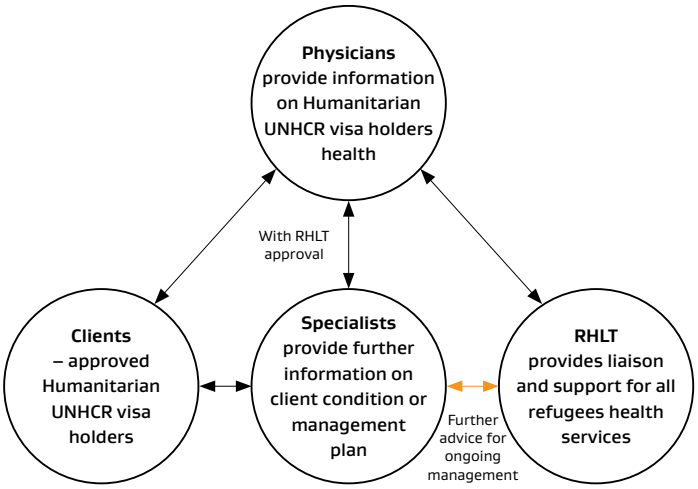
PART 1: PHYSICIANS AND INZ SETTLEMENT HEALTH SERVICES

Roles and Responsibilities for INZ Settlement Health Services

There are four key parties involved in settlement health services. These are the physician, INZ's Refugee Health Liaison Team (RHLT), specialists and clients. Each has a clear and distinct role that contributes to the settlement health process.



Physician

The role of the physician is to inform the client about the purpose of the assessment and to provide a comprehensive assessment of the client's current state of health and provide detail of their medical history as told by the client. All information observed and received is to be recorded as it is observed or told. This includes:

- applying appropriate medical, ethical and professional standards during the assessments and in completing any documentation
- ensuring that a parent or guardian is present when completing assessments for children under 18 years of age, or for incapable persons
- organising professional interpreters and/or chaperones if required
- capturing all information provided accurately and completely
- referring the client for standard blood tests as well as specific tests recommended in these panel physician instructions and discussing any other tests that may be appropriate given clinical or risk factors present with the RHLT
- arranging additional tests and specialist referrals as advised by the RHLT and transferring results and/or reports once completed
- ensuring that pre- and post-test counselling is carried out in accordance with local protocols and standards.
- attaching all documentation provided by the client
- it is essential to provide copies of all original vaccination records if available
- remaining accountable for any part(s) of the examination/ completion of the settlement health forms, that is delegated to a staff member within the practice.

INZ requires physicians providing settlement services to have the necessary medical expertise and experience to fulfil the above responsibilities.

For more information on the roles and responsibilities of panel physicians, refer to *New Zealand Immigration Panel Member Instructions (INZ 1216)*. Please note that these Settlement Health Instructions do not supersede the Panel Member Instructions.

Refugee Health Liaison Team

The role of the RHLT is to support the health and wellbeing of the client throughout their resettlement journey. This includes:

- prescribing and reviewing all settlement health forms
- requesting further information or tests from the physician or for referral to a specialist when required
- working with offshore and onshore health services to plan ongoing care for clients so that health services are accessible and meet the client's needs throughout the resettlement journey
- initiating and expanding health promotion, prevention and early intervention work with clients and refugee health services before and after resettlement
- providing liaison and support for all refugee health services and ensuring quality and consistency of advice and services.

Clients

The role of the client is to participate as fully with the settlement health services as they are comfortable. This includes:

- sharing their health history as accurately and with as much detail as they can
- supplying copies of all previous health documentation, including vaccination records, if available
- asking for clarification if they are uncertain about what is required or don't understand any part of the settlement health process

The assessments and vaccinations are voluntary and the client can choose to participate as they wish.

Specialists

A specialist assessment may be requested by the RHLT based on information provided during the settlement health process. If required, the role of the specialist will be to provide further assessment of the client to help plan the client's health management. This would usually include:

- a comprehensive assessment of the client's health condition
- a detailed report of the client's health condition and the specialist's recommendations for management
- communication with the referring physician and RHLT about a client's condition and management plan

Who can complete an INZ Settlement Health Form

Countries with panel physicians

In most countries, INZ uses a panel of reputable registered medical practitioners and/or radiologists. A global register of panel physicians can be found on the INZ website at https://www.immigration.govt.nz/new-zealand-visas/apply-for-a-visa/tools-and-information/tools/panel-physicians. All clients in these countries must have their settlement health forms completed by a panel physician.

For more information on panel physicians and INZ panel management, please refer to *New Zealand Immigration Panel Member Instructions (INZ 1216)*.

Countries with no listed panel physicians

For countries where there are no INZ panel physicians, a registered or board certified or licensed medical practitioner or physician may complete the settlement health form. INZ will require details of the registration, certification or board licence of the medical practitioner or physician.

Settlement health forms will not be accepted if completed by a nursing practitioner, a physician's assistant, or by other health practitioners.

Client Services

Cultural and language aspects of assessments

Physicians completing the settlement health forms should be aware of cultural expectations for health assessments and history-taking. If clients do not speak the language of the physician, a professional interpreter who is not related to the client must be provided.

Note: the physician must be satisfied as to the interpreter's impartiality, confidentiality and ability to interpret accurately. The interpreter should not be a family member or representing agent to avoid the risk of misinformation leading to a misdiagnosis.

Privacy considerations

To prevent misunderstandings, clients should be given information about what will happen during the settlement health process when they make an appointment including the need to remove clothing for the physical examination.

Aspects of the settlement health forms may make clients uncomfortable, such as breast examinations for women, and must be made known to clients at the time the appointment is made as well as on arrival at the clinic and before the physical examination starts.

Appendix 1 provides a diagram that you may wish to include when giving clients information about the settlement health forms and/or to display in your clinic waiting room, change and/or examination room.

Chaperones

All physical examinations should be conducted in a professional manner compatible with good practices and privacy at the expense of the physician. A chaperone must be offered and available during physical examinations for all clients. Details of the offer and the name of the chaperone must be accurately recorded in eMedical and on paper-based settlement health forms.

A parent or guardian must be present when a client under the age of 18, or an incapable person, is examined or x-rayed.

Particular attention should be taken with female clients. Even when a female family member accompanies a female client, it is advisable to have a female member of the clinic staff present.

Pregnant women

All women of reproductive age should be asked if they are or might be pregnant and about the date of their last menstrual period.

Pregnant women and vaccinations

- Live vaccinations are not recommended for women who are pregnant, however, other vaccinations should be encouraged.
- Do not give MMR to women who are pregnant or planning pregnancy. Advise women that they should not get pregnant 4 weeks after MMR.

Pregnant women and x-ray examinations

- INZ does not recommend x-ray exposure during pregnancy. Pregnant clients should be advised that they do not need to proceed with a chest x-ray examination.

Information sheet

eMedical-enabled clinics can provide clients with an information sheet for each settlement health form. The information sheets can be printed from eMedical at any time. The information sheet includes the:

- client photo
- INZ reference number (NZER)
- client personal details
- client identity details
- client visa details
- instructions for the client

The front page of the paper settlement health forms can also be detached and provided to the client if required.

Confirming the identity of clients

Physicians, and/or their clinic staff, must confirm the identity of all individuals who present for settlement health services. This is done by completing the identity questions included in eMedical or on paper settlement forms. For more information on how to confirm the identity of the individuals including photograph requirements, please refer to *New Zealand Immigration Panel Member Instructions (INZ 1216)*.

Disclosing of health information to clients

In all cases, physicians have a duty of care to clients in relation to health information. INZ strongly encourages physicians to have a defined process for recording, tracking and informing clients of health information, including assessments, laboratory results, imaging reports and other clinical opinions. Physicians must advise the client of any abnormal findings.

Automated email

There is no automated email functionality available in eMedical for settlement health services. Clients will be advised to contact the clinic where their assessments were completed if they require a copy of, or further information about their results. Clinics can use the 'Print Health Case' function within eMedical to generate a copy to print or save as a PDF and email to a client.

Specialist Referrals

The cost of specialist review will only be covered by INZ when the specialist referral has been approved by the RHLT. When making external referrals, physicians must explain to clients why further investigation is needed. Physicians should also explain that the results will be sent from the specialist to the physician who must then submit the reports to INZ, though clients should also be offered a copy. Specialist referral letters can be generated via eMedical.

The choice of a specialist is not limited; however high-quality reports are needed. Substandard reports will not be accepted by INZ. Physicians should refer clients to specialists in whom they have confidence in clinical skill and reporting.

Physicians must advise the specialist to:

- confirm the identity of the client
- provide results of all necessary investigations
- provide detailed reports including a description of the likely prognosis of the condition and recommended management
- provide reports in English or an original with an English translation

Specialist reports should clearly show the client's name, date of birth and identity document number. Original specialist reports are to be sent directly to the physician who should scan / upload and attach to eMedical or to a paper settlement health form.

Reports should be provided in English if possible. Reports in other languages should be translated into English by an accredited translator or by the physician themselves.

Submitting Settlement Health Forms

Physicians are to ensure that all requested sections of the form are completed. All answers must be in English. No grading is required on settlement health forms.

Settlement health forms completed in eMedical will be submitted automatically to INZ once all required forms are completed. Cases where there are no additional requirements should be submitted within five working days of the client attending the clinic.

Paper settlement health forms should also be submitted without delay, no more than five working days after the completion of the form. All documentation provided must be legible and each page initialled by the physician. For further information about completing paper forms, please refer to New Zealand Immigration Panel Member Instructions (INZ 1216).

Clinics have a responsibility to manage their caseload to ensure prompt submission of cases and to avoid any delays and inconvenience to clients.

How to contact INZ about settlement health services

All eMedical system support enquiries should be made via the support platform in eMedical: www.emedical.immi.gov.au.

All INZ clinical and processing enquiries relating to settlement health process should be emailed to: RHLT@mbie.govt.nz.

Please note that all INZ clinical and processing enquiries relating to the initial medical examination (visa medical processing) should continue to be emailed to: panelphysiciansupport@mbie.govt.nz.

PART 2: COMPLETING A *948 MEDICAL RESETTLEMENT NEEDS / SETTLEMENT HEALTH ASSESSMENT (INZ 1260)*

This part of the instructions provides advice about completion of the settlement health assessment for UNHCR-mandated refugees:

- eMedical enabled clinics must use the *948 Medical Resettlement Needs* form
- non-eMedical clinics will need to use the Settlement Health Assessment (INZ 1260) form (paper format)

Clients may require a professional interpreter or a chaperone to be present (please see 'privacy considerations' and 'chaperones' in Part 1). The details of the interpreter and/or chaperone must be recorded on the form.

The sections and questions below are listed in the order of the paper *Settlement Health Assessment (INZ 1260)*. The order may differ in the eMedical *948 Medical Resettlement Needs*.

SECTION A: PERSONAL DETAILS (eMEDICAL PRE-EXAM STAGE)

The questions in this section are for the purpose of confirming the identity of the client and their contact details.

Client visa category

Settlement health assessment forms should only be completed for clients who have been approved for a New Zealand resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category.

For eMedical enabled clinics, the *948 Medical Resettlement Needs* form will be prescribed for approved clients. For clinics without eMedical, the *Settlement Health Assessment (INZ 1260)* form is available for download from the INZ website www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments

Client identity

The examining physicians and/or their clinic staff must confirm the identity of all individuals who present for a settlement health assessment. INZ accepts the following documents to confirm an applicant's identity:

- Original passport
- Certificate of identity
- Refugee travel document
- National Identity Card with photo (as long as the identity card was issued by one of the following countries and the examining clinic is located in the issuing country)

  Albania
  Belgium
  Brazil
  Bulgaria
  Canada
  China People's Republic of
  Croatia
  Czech Republic
  Egypt
  France
  Germany
  Hong Kong (Special Administrative Region of the People's Republic of China)
  Hungary
  Indonesia
  Italy
  Malaysia
  Netherlands Antilles
  Pakistan
  Poland
  Portugal
  Russia - *Note: Internal passports are considered equivalent to a National Identity Card*
  Singapore
  South Korea
  Spain
  Sweden
  Taiwan
  Thailand
  Turkey

SECTION B: CLIENT CONSENT

The client consent must be signed and dated by the client in the presence of the physician. The physician must ensure that the client has read and/or had it read to them in their preferred language. This may require a professional interpreter.

There are two components of this assessment that the client can consent to:

- settlement health assessment, and any further tests as a result of this assessment
- vaccinations.

The client may choose to consent to both or only one of these components.

If there are any parts of the consent that the client doesn't understand, the physician will provide the information in vocabulary and language the client does understand so that informed consent can be gained. The physician must ensure the client understands the entire consent before witnessing the client signing

the consent. A parent or guardian must sign on behalf of a client who is under 18 years of age or who is an incapable person.

eMedical: 948 Medical Resettlement Needs – the consent must be printed, signed by the client and the physician, then scanned and attached within eMedical.

Paper: Settlement Health Assessment (INZ 1260) – the consent is included within the form. The client must sign the form in the presence of the physician. When signing the consent, the physician must also stamp the document with their name and address, or legibly print those details.

If a client does not consent to the settlement health assessment and/or vaccinations, the reason for this must be recorded.

If the client does not consent to the settlement assessment and vaccinations, and does not travel to the responsible clinic, the 'Decline in absentia' form needs to be completed by the physician. It is available for download from the INZ website www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments

This must then be submitted to the RHLT so they are aware that the client has opted out of the settlement health assessment at this time.

SECTION C: MEDICAL HISTORY

A physician must complete this section with the client. For a child who is younger than 18 years of age, or an incapable person, the medical history section must be completed by the physician together with a parent or guardian.

These questions are designed to assist the physician to complete an in-depth health screening of the client, with the view to:

- identifying the client's health concerns and planning health care early
- managing communicable diseases
- facilitating a smooth transition into the New Zealand Health system.

Be guided by the client's concern and document these even if they do not strictly fit within the parameters of the questions.

If the client answers 'Yes' to any question, note relevant details such as date of diagnosis, progress, current problems, complications and treatment so far. Attach any reports, tests and other information available. All items being attached to a paper settlement health form must be signed or initialled by the physician and securely attached.

C1. HAVE YOU EVER HAD PROLONGED MEDICAL TREATMENT AND/OR REPEATED HOSPITAL ADMISSIONS FOR ANY REASON, INCLUDING A MAJOR OPERATION OR PSYCHIATRIC ILLNESS?

Prolonged medical treatment may include:

- treatment for recurrent conditions
- treatment for conditions requiring treatment for more than two weeks
- physiotherapy, speech therapy or other therapies
- inpatient or outpatient care for a psychiatric illness.

Details must be provided about the type and length or treatment.

Regarding hospital admissions, the physician is expected to detail:

- the date/s of treatment
- the reason/s for treatment
- the type/s of treatment received.Document all procedures. Both inpatient and outpatient treatments are relevant. Hospital admissions for normal vaginal delivery do not need to be documented but all other obstetric and gynaecological history should be documented.

Regarding operations, the physician is expected to detail:

- the date and reason for the operation
- the operative procedure that was performed
- any available pathology or staging reports.

C2. DO YOU HAVE A HEART CONDITION INCLUDING CORONARY DISEASE, HYPERTENSION, VALVE OR CONGENITAL DISEASE?

Note any evidence of heart disease such as:

- chest pain, shortness of breath when lying down or with exercise, ankle swelling
- angina or ischaemic heart disease
- cardiac risk factors such as diabetes, smoking, family history of premature heart disease
- previous cardiovascular events such as angina, myocardial infarction, percutaneous coronary intervention, coronary artery bypass graft, severe peripheral vascular disease, familial lipid disorders, severe diabetes with nephropathy
- persistent uncontrolled hypertension
- heart murmur or valve disease
- cardiomyopathy
- aortic aneurysm
- rheumatic fever, past or present.

C3. DO YOU HAVE A RESPIRATORY CONDITION, INCLUDING ASTHMA, COPD, INTERSTITIAL LUNG DISEASE?

Note any evidence of respiratory disease such as:

- cough
- wheeze
- shortness of breath
- recurrent respiratory infections.

C4. DO YOU HAVE ANY GASTROINTESTINAL CONDITIONS, INCLUDING CROHN'S AND ULCERATIVE COLITIS, OR LIVER DISEASE?

Note any evidence of gastrointestinal disease such as:

- nausea and/or vomiting
- heartburn
- diarrhoea
- per rectal bleeding
- loss of appetite
- weight loss.

C5. DO YOU HAVE ANY MUSCULOSKELETAL CONDITIONS?

Note any evidence of musculoskeletal problems such as:

- gait abnormality
- muscle and joint pain and/or swelling
- muscle weakness and/or wasting
- history of injuries including fractures
- mobility aids.

If present, note impact of symptoms on function.

C6. DO YOU HAVE A NEUROLOGICAL CONDITION, INCLUDING HAVING HAD A STROKE OR MULTIPLE SCLEROSIS?

Note any evidence of neurological problems such as:

- any cognitive impairment or dementia, including Alzheimer's disease
- poorly controlled epilepsy or complex seizure disorder
- cerebrovascular disease such as transient ischaemic attacks or strokes
- cerebral palsy
- paraplegia, quadriplegia
- head or brain injury
- poliomyelitis
- Parkinson's disease
- motor neurone disease
- Huntington's disease
- muscular dystrophy
- prion disease
- relapsing and/or progressive multiple sclerosis.

C7. DO YOU SUFFER, OR HAVE YOU EVER SUFFERED, FROM A PSYCHOLOGICAL OR PSYCHIATRIC DISORDER (INCLUDING MAJOR DEPRESSION, BIPOLAR DISORDER OR SCHIZOPHRENIA)?

Note any evidence of major psychiatric illness including any psychiatric condition that has required hospitalisation and/or where significant support is required. This may include (but not limited to):

- bipolar disorder
- schizophrenia
- psychosis
- eating disorders
- post-traumatic stress disorder
- anxiety or depression.

If there is a history of mental illness, include details of:

- the specific diagnoses including personality disorders
- details of the type and duration of treatment including non-pharmacological treatment
- any history of non-compliance with treatment
- frequency of relapses
- an assessment of potential for self-harm or harm to others.

C8. DO YOU HAVE BLADDER OR KIDNEY PROBLEMS?

Note any evidence of bladder of kidney conditions such as:

- polycystic kidney disease, glomerulonephritis
- renal failure, dialysis, renal transplant
- family history of polycystic kidney disease or other hereditary kidney conditions
- incontinence (urge or stress)
- recurrent urinary tract infections.

C9. DO YOU HAVE A BLOOD CONDITION (INCLUDING THALASSAEMIA)?

Note any evidence of a blood condition such as:

- blood or blood product transfusions, indicate when and where and if any complications
- haemophilia, bleeding disorder, coagulopathies
- sickle cell disease, thalassaemia or other hereditary anaemias
- haemochromatosis
- any haematological malignancy such as leukaemia, lymphoma or myelodysplastic syndrome
- family history of blood conditions.

C10. DO YOU HAVE A HEREDITARY OR AUTOIMMUNE CONDITION?

Provide details of any hereditary or autoimmune condition, such as:

- any chromosomal, genetic, congenital or familial disorder such as Huntington's chorea, hyperlipidaemia, muscular dystrophies, cystic fibrosis, Down's syndrome
- any primary or acquired immunodeficiencies
- any inborn errors of metabolism
- personal or family history of Gaucher's disease
- any autoimmune condition including arthritis, lupus, psoriasis, Crohn's disease or other inflammatory bowel disease.

C11. DO YOU HAVE A THYROID CONDITION?

Provide details of any thyroid condition including:

- date of diagnosis
- progress
- current problems
- complications
- treatment so far.

C12. DO YOU HAVE COMMUNICABLE DISEASES?

Ask about risk factors and history of communicable diseases including (but not limited to):

- Tuberculosis
- Hepatitis B
- Hepatitis C
- Syphilis
- HIV
- Malaria
- Dengue.

C13. DO YOU HAVE HEARING OR VISION RELATED CONDITIONS?

Provide details of any hearing or vision related condition including:

- date of diagnosis
- progress
- current problems
- complications
- treatment.

C14. DO YOU HAVE A HEARING LOSS OR HAVE YOU NOTICED A DECREASE IN YOUR HEARING?

C15. DO YOU HAVE PAIN IN YOUR EARS?

C16. DO YOU HAVE A BLOCKED FEELING OR A FEELING OF PRESSURE IN YOUR EARS?

C17. DO YOU HAVE TINNITUS?

C18. DOES THE TINNITUS CAUSE YOU STRESS OR ANXIETY? (ONLY TO BE ANSWERED IF ANSWERED YES IN C17)

If the answer is yes, provide details including:

- Ear/s affected
- Date of onset and progress of symptoms
- Causative or contributing factors
- Impact on function
- Treatment/s.

C19. HAVE YOU EVER HAD ANY OPERATIONS ON YOUR EYES? IF YES PROVIDE DETAILS OF TREATMENT INCLUDING REASON, EFFECTIVENESS AND DATES

C20. HAVE YOU EVER HAD TO SEE AN EYE DOCTOR BEFORE?

C21. DOES ANYONE IN YOUR FAMILY HAVE ANY PROBLEMS WITH EYES? DESCRIBE PROBLEM AND TREATMENT.

If the answer is yes, provide details including:

- Reason for presentation
- Eye/s affected
- Date/s of assessment
- Treatment/s.

C22. DO YOU HAVE ANY DIFFICULTY DOING ANYTHING BECAUSE OF YOUR VISION?

If the answer is yes, ask for examples of impact on function e.g. unable to read without glasses.

C23. DO YOU HAVE AN ONGOING PHYSICAL OR INTELLECTUAL DISABILITY AFFECTING YOUR CURRENT OR FUTURE ABILITY TO FUNCTION INDEPENDENTLY OR BE ABLE TO WORK FULL-TIME (INCLUDING AUTISM OR DEVELOPMENTAL DELAY)?

INZ wishes to establish if further resources are required to assist with refugees who have a diagnosed long term issue with cognitive capacity. Note any evidence of physical, intellectual or developmental conditions, such as:

- physical disability
- intellectual disability
- autistic spectrum disorders
- brain injury.

Also provide details of:

- significant periods of time off work
- date last worked
- restrictions on work ability
- prognosis.

If there is a history of autism, Asperger's syndrome or special schooling, attach any existing report that is available from a paediatrician, clinical psychologist and/or other therapists.

C24. DO YOU HAVE ANY BIRTH OR DEVELOPMENTAL ISSUES (ONLY FOR CLIENTS AGED 5 OR LESS)

Ask parent/s or caregiver/s if they have any concerns about the client's development. Document all concerns.

C25. HAVE YOU EVER HAD AN ABNORMAL OR REACTIVE HIV BLOOD TEST?

Provide details of any abnormal or reactive HIV blood test including:

- date of test
- subsequent test/s
- follow up including diagnosis and/or treatment.

C26. HAVE YOU EVER HAD AN ABNORMAL OR REACTIVE HEPATITIS B OR HEPATITIS C BLOOD TEST?

Note relevant details including:

- date of diagnosis
- risk factors
- progress including recent liver function tests results if available
- management, if any, including management of contacts.

C27. DO YOU HAVE OR HAVE YOU HAD CANCER OR MALIGNANCY IN THE LAST 5 YEARS?

Provide details of malignancies of organs, skin and haematopoietic tissues including:

- dates
- sites
- staging
- histology reports
- treatments
- current status
- prognosis.

C28. DO YOU HAVE DIABETES?

Note any evidence of diabetes such as:

- sugar in the urine, polydipsia, polyuria
- positive diabetes tests
- history of gestational diabetes mellitus
- need for anti-hyperglycaemic medication
- end organ damage such as nephropathy, retinopathy, neuropathy, and peripheral vascular disease.

C29. DO YOU HAVE AN ADDICTION TO DRUGS OR ALCOHOL?

Note any known substance addictions. If there is any positive history of alcohol/drug abuse, note:

- any current use of alcohol or drugs
- any narcotic or intravenous drug use or addiction
- the history of any social or occupational consequences from the abuse/addiction
- addiction to prescription medications
- any history of detoxification or rehabilitation programmes
- the duration of abstinence
- triggers for drug and alcohol use.

C30. SMOKING HISTORY

If the client is a current cigarette smoker or has ever regularly smoked cigarettes for a period of six months or longer, the number of cigarettes smoked, the frequency, and the duration of smoking need to be documented.

If the client is an ex-smoker, the number of years they have been 'cigarette-free' should also be documented.

The physician should calculate the pack year history. Pack year history is a way to measure the amount a person has smoked over a long period of time. It is calculated by multiplying the number of packets of cigarettes smoked per day by the number of years the person has smoked:

- (Packs of twenty cigarettes per day) x (number of years smoked)
- Example 1: 10 cigarettes per day for 10 years = ½ x 10 = 5 pack year history
- Example 2: 40 cigarettes per day for 30 years = 2 x 30 = 60 pack year history.

C31. DO YOU HAVE ANY SIGNIFICANT FAMILY HEALTH HISTORY?

Ask the client if they have a parent or sibling:

- with a condition such as diabetes
- with cardiovascular/kidney/liver/blood/neurological disease
- with a genetic disorder
- with cancer
- who died due to illness before the age of 65.

Document the client's relationship to that person (e.g. father, sibling) and the nature of the condition.

If the client is a child under 15 years of age and either parent is HIV positive, document this.

C32. ARE YOU TAKING ANY MEDICATION (INCLUDING CONTRACEPTIVES, OVER-THE-COUNTER MEDICATION AND NATURAL SUPPLEMENTS)?

Provide a complete list of all medications including contraceptives, over the counter medications and natural supplements, with their doses and frequency. Complete the table with the medication (brand and generic), dose and frequency.

C33. DO YOU HAVE ANY KNOWN ALLERGIES (E.G. SPECIFIC MEDICATIONS OR FOOD TYPES)

Note any allergies and provide details including:

- allergen/s
- details of reaction e.g. rash, swelling, wheeze, diarrhoea
- treatment/s required
- date of last reaction.

SECTION D: PREGNANCY

D1. ARE YOU PREGNANT?

D2. WHAT IS THE EXPECTED DATE OF DELIVERY?

If the client has a letter from their own doctor or lead maternity carer (obstetrician) confirming their pregnancy, scan and attach it to the health case.

D3. ANY COMPLICATIONS TO DATE

Enquire as to whether the pregnancy is progressing normally. Provide details if there are any complications.

Ask about obstetric history including:

- previous gestational diabetes mellitus
- pre-eclampsia
- difficult deliveries
- previous premature babies
- prolonged labours
- recurrent miscarriage.

D4. HAVE RUBELLA STATUS, BLOOD GROUP, RHESUS FACTOR AND FERRITIN LEVEL MATERNITY BLOODS BEEN DONE?

Attach details of tests, if available, including:

- dates
- results.

D5. HAVE FOLIC ACID, IRON, IODINE SUPPLEMENTS BEEN PRESCRIBED?

If prescribed, record medication, dose and frequency in the table in C32.

SECTION E: PHYSICAL EXAMINATION

Clients must be advised that the physical examination includes an assessment of general appearance, a head-to-toe examination, and a mental health assessment. For the examination to provide the best information, they will be asked to remove sufficient clothing for a full and appropriate physical examination. A chaperone should be offered and details recorded if one was present.

Once the client is comfortable to be examined, proceed with the examination.

Where an abnormality is detected or declared, the physician must provide sufficient details regarding the nature, severity and possible/likely prognosis of the medical condition and/or disability to enable INZ to clearly understand and appreciate the client's state of health.

Delegating responsibility

The following measurements may be collected by staff supervised by the physician on the basis that the staff member concerned uses the equivalent skills that the physician would use to achieve the equivalent assessment result quality.

- Weight
- Height
- BMI
- Head circumference
- Visual acuity
- Blood pressure
- Urine testing.

If the physician delegates any part of the physical examination as above, this may only be performed by a registered nurse or registered medical practitioner for whose work the physician takes professional and legal responsibility.

Medical findings

Where an abnormality is detected or declared, the physician must provide sufficient details regarding the nature, severity and possible/likely prognosis of the medical condition and/or disability to enable INZ to clearly understand and appreciate the examined person's state of health.

The physician is to provide detailed comment on examination findings where:

- 'Yes' has been answered to a question in the 'Medical history' section
- There are pre-existing medical conditions (the client should provide any relevant reports they have)
- Abnormalities are present or are detected.

If medical reports have been provided by the client, attach these to the eMedical Settlement Health Assessment, or for paper-based medical certificates, authenticate these by initialling each page and attaching securely to the certificate.

Timely medical tests

All other medical tests required or indicated as a result of the examination should be carried out on or about the date of the medical examination.

E2. E3. HEIGHT AND WEIGHT

Record height in metres and weight in kilograms.

- A stadiometer fixed to the wall is recommended.
- When the client is unable to stand then record length on the application form.
- Adults and children must stand barefoot and wear lightweight clothing.
- Infants must be naked except for a diaper/nappy and recorded to the nearest 0.1kg.

E4. BMI

This will be automatically calculated in eMedical when required. For paper forms: body mass index (BMI) must be calculated for clients over 18 years of age.

- The formula is the weight (in kg) divided by the height (in m^2).

BMI calculators are available online, for example: www.healthnavigator.org.nz/bmi-calculator

E5. E6. HEIGHT PERCENTILE AND WEIGHT PERCENTILE

Record the nearest percentile. (www.health.govt.nz/our-work/life-stages/child-health/well-child-tamariki-ora-services/growth-charts)

Baby, infant and child height and weight must be compared to standardised height and weight chart for the appropriate population. Growth charts supplied can be accessed through the following links:

- Centre for Adoption Medicine: www.adoptmed.org/topics/growth-charts.html. This includes links to country specific growth charts.
- CDC: www.cdc.gov/growthcharts/charts.htm

E7. E8. HEAD CIRCUMFERENCE

Record the head circumference in all children up to two years of age:

- Assess greatest occipitofrontal circumference.

Compare measurement with the standardised head circumference chart for the appropriate population. Growth charts supplied can be accessed through the following links:

- Centre for Adoption Medicine: www.adoptmed.org/topics/growth-charts.html. This includes links to country specific growth charts.
- CDC: www.cdc.gov/growthcharts/charts.htm

E9. E10. BLOOD PRESSURE

Blood pressure must be measured for all clients over 15 years using an appropriate cuff size.

If blood pressure is elevated, repeat after the patient has rested for five minutes and, if necessary, again after 10 minutes.

If concerned about postural hypotension or left to right shunts, record sitting and standing blood pressures and side that blood pressure was taken on. Record these additional blood pressure readings under E18: Cardiovascular System.

E11. TEMPERATURE

Take temperature. Record temperature if abnormal.

E12. RESPIRATORY RATE

E13. HEART RATE

Measure rate per minute and record in respective field.

E14. HEART RHYTHM

Assess rhythm clinically e.g. regular, regularly irregular, irregularly irregular. Add description of rhythm after heart rate in E13. To confirm heart rhythm, do an ECG.

E15. E16. E17. URINALYSIS

Check appropriate box for dipstick findings.

E18. CARDIOVASCULAR SYSTEM

Assessment includes:

- cyanosis, pallor, peripheral temperature and oedema
- additional blood pressures readings as indicated (e.g. standing and sitting, left arm and right arm)
- size and consistency of thyroid gland, including any masses
- jugular venous pressure
- palpation for thrills and character of apex beat
- auscultation of heart sounds, extra sounds and murmurs
- peripheral vascular system: carotid, radial, femoral, posterior tibial and dorsalis pedis
- carotid and femoral bruits.

All abnormalities must be noted.

E19. RESPIRATORY SYSTEM

Assessment includes:

- respiratory rate
- any respiratory distress, cyanosis and accessory muscle use
- position of trachea
- cervical lymphadenopathy
- chest shape and expansion
- percussion of the chest
- auscultation of breath sounds
- finger clubbing
- peak expiratory flow rate (especially for clients with a 20 pack year or more smoking history)
- good quality spirometry if possible.

All respiratory abnormalities must be noted.

E20. NERVOUS SYSTEM: SEQUELAE OF STROKE OR CEREBRAL PALSY, OTHER NEUROLOGICAL DISABILITIES

Assessment includes:

- cranial nerves (visual assessment, face sensation and movement, hearing, tongue)
- tone
- power
- reflexes
- sensation to light touch, pin prick
- plantar responses
- coordination
- gait
- Romberg's test.

E21. GASTROINTESTINAL SYSTEM

Assessment includes:

- stoma sites
- ascites, distension
- tenderness, masses, guarding
- liver, spleen, kidneys
- bowel sounds
- hernias
- femoral pulses and bruits
- any unexplained weight loss.

Abnormalities must be noted.

E22. MUSCULOSKELETAL SYSTEM

Assessment includes:

- inspection of joints, muscle and the skeletal system looking for erythema, swelling, tenderness, nodules, lumps, range of motion, any deformities and ability to stand from squatting
- mobility and locomotion, limping
- use of accessories such as braces, walking aids or wheelchairs.

All abnormalities must be noted. If there concerns about managing activities of daily living, complete an activities of daily living (ADL) assessment (Appendix 2).

E23. ENDOCRINE SYSTEM

Examination of the endocrine system should include thyroid examination and review of signs and symptoms of diabetes. Clients known to have benign thyroid disease do not need additional investigations such as thyroid function tests.

E24. EYES (INCLUDING FUNDOSCOPY)

Examination should include physical inspection of the eye for deposits in the iris, xanthelasma, lid issues and eye motility.

E25. MENTAL AND COGNITIVE STATUS

Mental health conditions can be at times particularly difficult to identify. Assess for a recent history or current clinical evidence of the following:

- schizophrenia
- bipolar or depressive affective psychosis
- personality disorder
- paranoid disorder
- autism
- chronic alcohol abuse
- drug dependence or substance abuse
- eating disorders
- chronic neurosis (for example, chronic anxiety or depression, obsessive compulsive disorder, phobias).

Assess cognition if the client is over 70 years of age or there is concern that the client may have a cognitive or memory deficit.

Complete the Rowland Universal Dementia Assessment Scale (RUDAS) screening test www.immigration.govt.nz/documents/industry/rudasdementiascreeningform.pdf. The test questions should be performed in the client's own language or with the assistance of a professional interpreter. If a language barrier to assessment is present, this should be recorded. For more information on administering RUDAS, see the RUDAS Administration Guide. www.immigration.govt.nz/documents/industry/rudasadministrationguide.pdf

E26. INTELLECTUAL ABILITY

If intellectual ability is abnormal, document all concerns.

Assess:

- behaviour
- need for long-term supported or special education
- level of independence and need for assistance or institutional care
- employment capacity and occupation history.

E27. VISUAL ACUITY WITH OR WITHOUT CORRECTION

Test the client's best vision. The visual acuity of each eye must be tested separately with corrective lenses if worn. If the client usually wears corrective lenses but has not brought them in on the day, document this. Snellen's, E or similar charts must be used.

If a refractive defect is suspected, pinhole testing must be done.

Corrected visual acuity must be recorded. In children too young to use a chart, a comment must be made on whether vision appears normal.

E29. HEARING

Assessment includes:

- either grossly or with an audiogram where possible
- each ear must be tested separately
- in young children, a comment must be made on whether hearing appears normal.

All abnormalities must be noted.

E30. EAR/NOSE/THROAT/MOUTH

Assessment includes:

- external ear, auditory canal, ear drums, general hearing
- nasal obstruction and discharge
- oral cavity, tongue (including under) and pharynx
- teeth (including under dentures if any) and gingiva
- any masses, leukoplakia and other abnormalities.

All abnormalities must be noted.

E31. DEVELOPMENTAL MILESTONES (CHILDREN UNDER FIVE YEARS OF AGE)

Assessment includes the following critical developmental milestones:

- cannot hold head up unsupported at eight or more months (normal four months)
- cannot sit unsupported at nine months (normal eight months)
- cannot walk at 18 months (normal 13 months)
- no words by 18 months (normal 15 months)
- no two–three-word phrases by 24 months and 40 months respectively (normal 21 and 36 months respectively)
- Moro reflex persisting at six or more months.

For further milestones, see Child Development Milestone Guidelines (appendix 3). All abnormalities must be noted.

E32. SKIN AND LYMPH NODES

Assessment includes:

- scars - note scars from surgical procedures and significant injuries
- tattoos – as INZ screen for various infectious diseases, including Hepatitis C, it is not necessary to comment on tattoos. Please only provide details relating to tattoos if there are specific concerns.
- skin conditions and lesions
- lymph nodes: cervical, axillary, inguinal
- cervical nodes in children: submental, submandibular, anterior and posterior cervical, pre- and post-auricular, suboccipital and supraclavicular lymph nodes are not usually palpable in children who are well. If they are palpable, consider tuberculosis.

Abnormalities must be noted. Referral to an appropriate physician is necessary for:

- palpable cervical lymph nodes in children
- unexplained lymphadenopathy
- unstable, progressive, symptomatic or complicated conditions
- any condition likely to significantly affect the client's ability to function at home, study or work or perform activities of daily living.

Note: In male and female clients, examination of the external genitalia should only be done if clinical evidence is presented to indicate a condition requiring assessment. Rectal examination is rarely, if ever, indicated. If either of these sensitive examinations is necessary, always explain clearly to the client the reason for the examination, check their understanding and offer a chaperone and the presence of a family member. Document this conversation in detail.

Gynaecological examination (vaginal or pelvic examination) is never indicated in the context of a settlement health examination. If there has been a history or clinical suspicion of gynaecological malignancy that has been identified in the settlement health assessment, discuss with RHLT about referral to a gynaecologist.

E33. BCG

Mark as normal if absent. Mark as abnormal if present and provide details about scar including size and location.

E34. BREAST EXAMINATION ON WOMEN OVER 45 YEARS OF AGE

Examinations should only be done if there is a clinical indication and must be conducted with sensitivity and, in the case of a male physician, with the presence of a chaperone. If examination is necessary, always explain clearly to the client the reason for the examination and check their understanding. Document this conversation in detail.

Assessment includes:

- nipple symmetry, eversion and discharge
- evidence of peau d'orange or skin changes around the nipple
- breast lumps or cancers, and
- axillary lymph nodes. All abnormalities must be noted. Record benign breast lesions such as fibroadenoma or fibrocystic disease.

E35. ANY PHYSICAL OR MENTAL CONDITIONS WHICH MAY PREVENT THIS PERSON FROM ATTENDING A MAINSTREAM SCHOOL, GAINING FULL EMPLOYMENT OR LIVING INDEPENDENTLY NOW OR IN THE FUTURE?

Consider any condition or finding that has current or likely future impact, on the client's capacity for independent living and/or employment, and provide full details. Assessment includes:

- eating, drinking, dressing, washing, toileting, bladder and bowel control, mobility and locomotion
- communication, comprehension, expression
- social cognition, social interaction
- memory
- need for devices, aides or assistance.

All abnormalities must be noted.

Activities of Daily Living (ADL) needs to be assessed for any client where there is concern about their ability to carry out the activities of daily living, including the frail elderly. See ADLs assessment (Appendix 2).

Where there is concern about capacity for full employment, provide details of any anticipated employment restrictions.

Full details should be provided of any required rehabilitation services currently being provided to the client, or which will be needed in the future.

E36. EVIDENCE OF DRUG-TAKING

Assessment includes:

- puncture marks, phlebitis
- mental state
- smell of alcohol on the breath, signs of chronic liver disease in the context of alcohol dependence
- any other indicators of drug-taking or addiction.

All abnormalities must be noted.

SECTION F: SETTLEMENT VACCINATIONS

Ensure copies of all documentation of previous vaccines are attached in this section and labelled as vaccinations.

Record all contraindications.

If the client advises that they have been vaccinated but has no documented evidence of this, this must be recorded and they must be treated as if they were not vaccinated. In this case, complete the Absent Vaccination Documentation and attach this to the Settlement Health assessment. The Absent Vaccination Documentation form is available for download from the INZ website : www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments

Offer vaccinations according to New Zealand's Immunisation Schedule. https://www.immune.org.nz/new-zealand-national-immunisation-schedule.

If required, plan and complete a catch up schedule of vaccinations. Follow guidance from Immunisation Handbook: Planning Immunisation Catch-Ups in the New Zealand Immunisation www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Record all vaccines given.

For further information about vaccinations, see the New Zealand Immunisation Handbook 2020 www.health.govt.nz/our-work/immunisation-handbook-2020

Chapters of specific interest include:

Planning Immunisation Catch-Ups

www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Immunisation of special groups

https://www.health.govt.nz/our-work/immunisation-handbook-2020/4-immunisation-special-groups including pregnancy and lactation, immunocompromised individuals, chronic kidney disease, chronic liver disease

Processes for safe immunisations

https://www.health.govt.nz/our-work/immunisation-handbook-2020/2-processes-safe-immunisation which covers pre-vaccination screening in 2.1.3, with condition or circumstance to screen for (e.g. is pregnant, has a disease that lowers immunity), what actions to take and the rationale for this. This chapter also covers contraindications in 2.1.4 and post-vaccine advice in 2.3.1.

F1 EXAM DATE

Record the date the exam was completed.

F2 CONTRAINDICATIONS

Provide details of any contraindications.

F4 DISEASE / VACCINE:

Provide the name of the vaccine given.

Administered by clinic: (must be completed).

Batch number: As displayed on vaccine vial (must be completed).

Batch expiry: As displayed on vaccine vial (must be completed).

Route: Mark which route used (must be completed).

Waiver reasons: Only mark if any applies (can be left blank).

F5 MEASLES, MUMPS, RUBELLA, HEPATITIS B, POLIO & VARICELLA

Test for immunity positive

Record if test for immunity was previously done and date of test. If more than one immunity test was done, supply all records. There is no need to arrange immunity tests if not previously done.

F6 VARICELLA

Has the client had the disease? Document if the client has a history of having Varicella. Indicate yes or no.

SECTION G: LABORATORY TESTS

Physicians should perform specimen collection onsite. If the physician delegates this procedure to a nurse or phlebotomist, the physician remains accountable for the integrity of the procedure. For further information about specimen integrity, please refer to *New Zealand Immigration Panel Member Instructions (INZ 1216)*.

The physician must select trusted laboratories to perform the tests required by INZ.

The physician must discuss the nature of testing with the client or, if the client is a person under 18 years of age or an incapable person, with the client's parent or guardian. Where applicable the physician should explain:

- standard tests that are advised as a part of the settlement health services

- the nature and reason for any discretionary tests
- that all test results will be provided to INZ.

It is compulsory to record and attach results for all laboratory tests. When reviewing the laboratory tests, ensure that the person collecting the blood, and/or receiving the laboratory specimens has confirmed the client's identity to confirm that the samples were collected from the individual identified on the settlement health form.

Each of these tests requires a number value or 'nonreactive/reactive' response by the physician. The laboratory reference standard ranges for each test must be included in the results. Where the test(s) is serological for antibodies or antigens, the laboratory test used must also be specified.

eMedical: *948 Medical Resettlement Needs* – Referral forms for laboratory tests can be generated using standard eMedical functionality. Please refer to the training guides within eMedical (module 9 – Examinations, section 9.6 Pathology and Other examinations) for more information if required.

Paper: *Settlement Health Assessment (INZ 1260)* – The laboratory referral form (Section J) is included and comprises two pages to be detached and given to the client to take to the laboratory for completion. The physician is to sign and date the form, including adequate address details where the results and the completed 'Section K: Confirmation of identity and declaration' are to be returned.

Please provide these pages of the form to the client along with directions to the laboratory. A separate laboratory referral form should be provided for each set of laboratory tests.

It is acceptable for physicians to use their own laboratory forms/process, with the proviso that 'Section K: Confirmation of identity and declaration' is still completed at the time of specimen collection, by both the client and the person collecting the specimens.

Laboratory reports must be initialled on each page and securely attached to the health form.

Abnormal laboratory tests

If a client's laboratory tests are abnormal, the physician should arrange additional testing as indicated below, and seek advice from RHLT at RHLT@mbie.govt.nz.

The following points need to be covered in discussion with the client where applicable, bearing in mind local ethical standards and requirements:

- Information about the tests and results
- Implications and possible prognosis
- Ways of transmission of the organism/s
- Ways of protecting others from infection with the organisms, in particular, the vaccination of close contacts of hepatitis B carriers
- Ways of minimising future complications
- Referral for medical intervention as discussed with RHLT. The physician is to detail any referral in the Laboratory Test 'Remarks' field.

Standard laboratory tests

The following blood tests are advised for all clients:

- HBsAg
- Hep C Antibody
- HIV serology
- Syphilis test.

The following blood tests are advised for all clients 40 years of age and over or where clinically indicated:

- HbA1C.

Urinalysis is required for clients 5 years and older.

Following up abnormal laboratory test results

The following tests can be organised without discussing with RHLT. If considering other follow up tests or local alternatives, discuss with RHLT at RHLT@mbie.govt.nz before undertaking.

Test	Follow up of abnormal results
HbA1C (in mmol/mol)	If >50mmol/mol, add serum creatinine, eGFR, lipids, TSH and urinary albumin:creatinine ratio.
Hepatitis B surface antigen positive	Add: › Hepatitis B e-antigen › HBV DNA › LFTs › AFP, if over 30 years of age
Hepatitis C serology positive	Add HCV-RNA.
Syphilis screening	Local screening test for syphilis should be done. All positive tests must be confirmed with a treponemal specific test: › treponema pallidum particle agglutination test (TP-PA) › fluorescent treponemal antibody absorption test (FTA-ABS), or › microhaemagglutination for treponema pallidum (MHA-TP). If positive then please provide specific details regarding any management required or given (including drug names, doses and dates).
Dipstick urinalysis positive for albumin, protein, red cells, glucose AND the female client does not have her period (menstruation)	Add mid-stream urine sample. Send to laboratory for examination of red cell casts or dysmorphic cells on microscopy. If positive for glucose check HBA1C if not already done, and add albumin:creatinine ratio. If positive for blood, request culture and sensitivity. If protein positive, request creatinine and eGFR if not already done.
Haematuria Greater than 10 cells per high power field AND the female client does not have her period (menstruation)	Repeat urine microscopy for confirmation and trend.

Discretionary laboratory tests

The physician should consider additional tests in any age group, due to indications from the medical history or physical examination findings, or known local conditions and risks (e.g. the local risks of Trypanosoma cruzi for Latin America and Spain). HIV testing for children <15 years of age is strongly recommended if their mother is HIV positive or if the child has history of blood or blood product transfusion. Discuss discretionary laboratory tests with RHLT at RHLT@mbie.govt.nz before undertaking.

Below is guidance for follow up of abnormal results for common discretionary laboratory tests. Tests recommended as part of this guidance can be organised without discussing with RHLT. Any other follow up tests need to be discussed with RHLT at RHLT@mbie.govt.nz before undertaking.

Test	Follow up of abnormal results
Estimated glomerular filtration rate (eGFR) in mL/min/1.73m2	› Ensure the client is well hydrated and repeat. › Where eGFR is not available, creatinine clearance must be done (involves 24-hour urine collection).
HIV positive	Add confirmatory tests such as Western Blot test or line-blot test.
Full blood count The following tests are required: Hb – haemoglobin in g/L WCC – total white cell count cells x 109/L PLATS – platelet count cells x 109/L	If abnormal result, repeat test after a period for two weeks for trend. If abnormality is low haemoglobin, add ferritin test when doing repeat testing. If significantly abnormal result, discuss with RHLT. Enter values as whole numbers with the exception of the White Blood Cells which should be recorded to one decimal place.
Liver function tests. Should include: › total bilirubin › alkaline phosphatase › AST – aspartate aminotransferase (SGOT) › ALT – alanine aminotransferase (SGPT) › GGT – gamma glutamyltransferase › Albumin › total protein	If abnormal, discuss further testing with RHLT.
Lipids These do not need to be fasting lipids. A full Lipid Profile should be provided: Total cholesterol; LDL; HDL; Triglycerides; Chol:HDL ratio.	Repeat testing not routinely required. Discuss with RHLT if concerns.

PART 3: COMPLETING A *956 SETTLEMENT ADDITIONAL INFORMATION / SETTLEMENT ADDITIONAL INFORMATION (INZ 1364)*

This part of the instructions provides advice about completion of the settlement additional information requests for UNHCR-mandated refugees:

- eMedical enabled clinics must use the *956 Settlement Additional Information form*.
- non-eMedical clinics need to complete the paper *Settlement Health Additional Information (INZ 1364)* form available at annawww.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments

The sections and questions below are listed in the order of the eMedical *956 Settlement Additional information / Settlement Additional Information (INZ 1364)*.

SECTION: RECORD RESULTS

The questions in this section are for the purpose of confirming the date the exam was completed and the type of exam, as well as for documenting additional information requested by the RHLT.

Exam date: Record the date the exam was completed.

Exam Description: On the eMedical form, this will be auto-populated with the description requested by RHLT. For paper medicals, write the description requested by RHLT.

Provide details: Provide details about the information requested by RHLT. If an interpreter or chaperone was required, record their details.

SECTION: ATTACHMENTS

This section enables the attachment of documents to support the tasks/information requested in the *956 Settlement Additional information* by the RHLT Team.

Please provide documents in English. If original documents need to be translated to English by either the physician or professional interpreter, provide original as well as the translated document.

Naming of Attachments

Name the file using a description of the attachment e.g. if you are attaching a discharge summary from a hospital admission, name the file 'Hospital discharge summary related to [medical condition]'.

PART 4: COMPLETING *953 SETTLEMENT VACCINATIONS / SETTLEMENT VACCINATIONS (INZ 1251)*

This part of the instructions provides advice about completion of the Settlement Vaccination form.

It allows the recording of vaccinations given to UNHCR-mandated refugees.

- eMedical-enabled clinics **must** use the *953 Settlement Vaccination: Record Results* form.
- Non-eMedical clinics need to complete *Settlement Vaccinations (INZ 1251)* which is available at www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments.

The sections and questions below are listed in the order of the eMedical *953 Settlement Vaccination: Record Results*.

SECTION: SETTLEMENT VACCINATIONS

The questions in this section are for providing an accurate record for any vaccines that have been provided by your clinic.

Offer vaccinations according to New Zealand's Immunisation Schedule www.immune.org.nz/new-zealand-national-immunisation-schedule.

If required, continue catch up schedule of vaccinations. Follow guidance from Immunisation Handbook: Planning Immunisation Catch-Ups in the New Zealand Immunisation https://www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Record all vaccinations.

For further information about vaccinations, see the New Zealand Immunisation Handbook 2020 www.health.govt.nz/our-work/immunisation-handbook-2020

Chapters of specific interest include:

Planning Immunisation Catch-Ups

www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Immunisation of special groups

www.health.govt.nz/our-work/immunisation-handbook-2020/4-immunisation-special-groups
Topics include pregnancy and lactation, immunocompromised individuals, chronic kidney disease and chronic liver disease.

Processes for safe immunisations

https://www.health.govt.nz/our-work/immunisation-handbook-2020/2-processes-safe-immunisation which covers pre-vaccination screening in 2.1.3, with conditions or circumstances to screen for (e.g. is pregnant, has a disease that lowers immunity), what actions to take and the rationale for this. This chapter also covers contraindications in 2.1.4 and post-vaccine advice in 2.3.1.

Exam date

Record the date the exam was completed.

Contraindications

Provide details of any contraindications.

Disease / vaccine

Provide the name of the vaccine given.

Administered by clinic: (must be completed).

Batch number: As displayed on vaccine vial (must be completed).

Batch expiry: As displayed on vaccine vial (must be completed).

Route: Mark which route used (must be completed).

Waiver reasons: Only mark if any applies (can be left blank).

Remarks: Document any additional information or issues (can be left blank).

MEASLES, MUMPS, RUBELLA, HEPATITIS B, POLIO & VARICELLA

Test for immunity positive

Record if test for immunity was previously done and the date of the test. If more than one immunity test was done, supply all records. There is no need to arrange immunity tests if not previously done.

VARICELLA

Has the client had the disease? Document if the client has a history of having Varicella. Indicate yes or no.

Attachments

If a client has documentation of previous vaccines, attach these and name the attachment 'Previous vaccination documentation'.

If the client advises that they have been vaccinated but there is no documented evidence of this, document this using the *Absent Vaccination Documentation Record (INZ 1253)* available at www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments and arrange vaccinations as if they were not vaccinated.

PART 5: COMPLETING *949 DEPARTURE HEALTH CHECK / DEPARTURE HEALTH CHECK (INZ 1262)*

This part of the instructions provides advice about completion of a departure health check for UNHCR-mandated refugees:

- eMedical enabled clinics **must** use the *949 Medical Resettlement Needs* form.
- non-eMedical clinics need to use the *Departure Health Check (INZ 1262)* form (paper format) available at www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments.

Clients may require a professional interpreter or a chaperone to be present (please see 'privacy considerations' and 'chaperones' in Part 1). The details of the interpreter and/or chaperone must be recorded on the form.

The sections and questions below are listed in the order of the eMedical *949 Departure Health Check*.

SECTION A: PERSONAL DETAILS

The questions in this section are for the purpose of confirming the identity of the client and their contact details.

Client visa category

Departure Health Check should only be completed for clients who have been approved for a New Zealand resident visa under New Zealand's Refugee Quota Programme or the Refugee Quota Family Reunification Category.

For eMedical-enabled clinics, the 949 Departure Health Check form will be prescribed for approved clients. For clinics without eMedical, the *Departure Health Check (INZ 1262)* form is available at www.immigration.govt.nz/assist-migrants-and-students/other-industry-partners/panel-physician-network/refugee-settlement-health-assessments

Client identity

The examining physicians and/or their clinic staff must confirm the identity of all individuals who present for a Departure Health Check. INZ accepts the following documents to confirm an applicant's identity:

- Original passport
- Certificate of identity
- Refugee travel document
- National Identity Card with photo (as long as the identity card was issued by one of the following countries and the examining clinic is located in the issuing country)

  Albania
  Belgium
  Brazil
  Bulgaria
  Canada
  China, People's Republic of
  Croatia
  Czech Republic
  Egypt
  France
  Germany
  Hong Kong (Special Administrative Region of the People's Republic of China)
  Hungary
  Indonesia
  Italy
  Malaysia
  Netherlands Antilles
  Pakistan
  Poland
  Portugal
  Russia – *Note: Internal passports are considered equivalent to a National Identity Card*.
  Singapore
  South Korea
  Spain
  Sweden
  Taiwan
  Thailand
  Turkey.

SECTION B: CLIENT CONSENT

The client consent must be signed and dated by the client in the presence of the physician. The physician must ensure that the client has read and/or had it read to them in their preferred language. This may require a professional interpreter.

If there are any parts of the consent that the client doesn't understand, the physician will provide the information in vocabulary and language the client does understand so that informed consent can be gained. The physician must ensure the client understands the entire consent before witnessing the client signing the consent. A parent or guardian must sign on behalf of a client who is under 18 years of age or who is an incapable person.

EMedical: 949 Departure Health Check – the consent must be printed, signed by the client and the physician, then scanned and attached within eMedical.

Paper: Departure Health Check (INZ 1262) – the consent is included within the form. The client must sign the form in the presence of the physician. When signing the consent, the physician must also stamp the document with their name and address, or legibly print those details.

If a client does not consent to the *Departure Health Check*, the reason for this must be recorded.

If the client does not consent to the *Departure Health Check*, and does not travel to the responsible clinic, the Decline Consent in Absentia (INZ 1254) form (found at www.immigration.govt.nz/documents/forms-and-guides/inz1254.pdf) needs to be completed by the physician. This must then be submitted to the RHLT so it is aware that the client has opted out of the *Departure Health Check* at this time.

SECTION C: GENERAL MEDICAL EXAMINATION

Clients must be advised that the physical examination includes an assessment of general appearance, a head-to-toe examination, and a mental health assessment. For the examination to provide the best information, they will be asked to remove sufficient clothing for a full and appropriate physical examination. A chaperone should be offered and details recorded if one was present.

Once the client is comfortable to be examined, proceed with the examination.

Where an abnormality is detected or declared, the physician must provide sufficient details regarding the nature, severity and possible/likely prognosis of the medical condition and/or disability to enable INZ to clearly understand and appreciate the client's state of health.

Delegating responsibility

The following measurements may be collected by staff supervised by the physician on the basis that the staff member concerned uses the equivalent skills that the physician would use to achieve the equivalent assessment result quality.

- Weight
- Height
- BMI
- Head circumference
- Visual acuity
- Blood pressure
- Urine testing.

If the physician delegates any part of the physical examination as above, this may only be performed by a registered nurse or registered medical practitioner for whose work the physician takes professional and legal responsibility.

Medical findings

Where an abnormality is detected or declared, the physician must provide sufficient details regarding the nature, severity and possible/likely prognosis of the medical condition and/or disability to enable INZ to clearly understand and appreciate the examined person's state of health.

The physician is to provide detailed comment on examination findings where:

- 'Yes' has been answered to a question in the 'Mental Health Condition' section
- There are pre-existing medical conditions (the client should provide any relevant reports they have)
- Abnormalities are present or are detected.

If medical reports have been provided by the client, attach these to the *Departure Health Check*, or for paper-based medical certificates, authenticate these by initialling each page and attaching securely to the certificate.

Timely medical tests

All other medical tests required or indicated as a result of the examination should be carried out on or about the date of the medical examination. The Departure Health Check and all attachments need to be submitted within 72 hours of finalisation.

C1. EXAM DATE:

Record date exam was conducted.

C2. OVERALL PHYSICAL CONDITION

If you indicated 'Abnormal', provide full details on what is abnormal. Please also indicate whether this is a temporary or a permanent abnormality.

C3 C4. HEIGHT AND WEIGHT

Record height in metres and weight in kilograms.

- A stadiometer fixed to the wall is recommended.
- When the client is unable to stand then record length on the application form.
- Adults and children must stand barefoot and wear lightweight clothing.
- Infants must be naked except for a diaper/nappy and recorded to the nearest 0.1kg.

C5. BMI

This will be automatically calculated in eMedical when required. For paper forms: body mass index (BMI) must be calculated for clients over 18 years of age.

- The formula is the weight (in kg) divided by the height (in m2).

BMI calculators are available online, for example: www.healthnavigator.org.nz/bmi-calculator

C5. C6. HEIGHT PERCENTILE AND WEIGHT PERCENTILE

Record to the nearest percentile. (www.health.govt.nz/our-work/life-stages/child-health/well-child-tamariki-ora-services/growth-charts)

Baby, infant and child height and weight must be compared to standardised height and weight chart for the appropriate population. Growth charts supplied can be accessed through the following links:

- Centre for Adoption Medicine: www.adoptmed.org/topics/growth-charts.html. This includes links to country specific growth charts.
- CDC: www.cdc.gov/growthcharts/charts.htm

C8. HEAD CIRCUMFERENCE

Record the head circumference in all children up to two years of age:

- Assess greatest occipitofrontal circumference.

C9. C10. BLOOD PRESSURE

Blood pressure must be measured for all clients over 15 years using an appropriate cuff size.

If blood pressure is elevated, repeat after the patient has rested for five minutes and, if necessary, again after 10 minutes.

If concerned about postural hypotension or left to right shunts, record sitting and standing blood pressures and side that blood pressure was taken on. Record these additional blood pressure readings under C2. Overall physical condition.

C11. HEART RATE

Measure rate per minute and record in respective field.

C12. RESPIRATORY RATE

Measure rate per minute and record in respective field.

C13. MOUTH /THROAT

Assessment includes:

- nasal obstruction and discharge
- oral cavity, tongue (including under) and pharynx
- teeth (including under dentures if any) and gingiva
- any masses, leukoplakia and other abnormalities.

All abnormalities must be noted.

C14. TEMPERATURE

Take temperature. Record temperature if abnormal.

C15. ABDOMINAL EXAMINATION FOR MASSES

Assessment includes:

- ascites, distension
- tenderness, masses, guarding.

Abnormalities must be noted.

C16. SKIN

Assessment includes:

- scars - note scars from surgical procedures and significant injuries
- Tattoos – as INZ screens for various infectious diseases including Hepatitis C, it is not necessary to comment on tattoos. Please only provide details relating to tattoos if there are specific concerns.
- skin conditions and lesions
- lymph nodes: cervical, axillary, inguinal
- Cervical nodes in children: submental, submandibular, anterior and posterior cervical, pre- and post-auricular, sub occipital and supraclavicular lymph nodes are not usually palpable in children who are well. If they are palpable, consider tuberculosis.

Abnormalities must be noted.

C17. LEGS AND FEET (PRESENCE OF INFESTATIONS OR INFECTIONS)

Mark the appropriate box. If abnormal, provide details of infection and any treatment.

Significant medical conditions

C18. HEARING

Each ear must be tested separately. In young children, indicate whether hearing appears normal.

All abnormalities must be noted.

C19. VISION

Test the client's best vision. The visual acuity of each eye must be tested separately with corrective lenses if worn. If the client usually wears corrective lenses but has not brought them on the day, document this. Snellen's, E or similar charts must be used.

Corrected visual acuity must be recorded. In children too young to use a chart, a comment must be made on whether vision appears normal.

C20. LEARNING/DEVELOPMENT

Provide details on what special attention is required for travel.

C21. COMMUNICATING

Provide details on any difficulties with communicating.

C22. MOBILITY

If anything other than 'Normal', provide full details on what mobility aids are used in Q23 or what is required in Q24.

C25. TRAUMA/INJURY

If anything other than 'Normal', provide full details on what the trauma/injury is and how it may affect travel.

C26 COGNITION

If anything other than 'Normal', provide full details on what the cognition issues are and how it may affect travel.

Mental health condition

Questions C27 to C32 are to be answered for clients aged 15 years and older.

For clients under the age of 15, go to questions C33 to C37 and answer these with the assistance of a parent/ legal guardian.

If anything other than 'Normal', provide full details.

For 15 years and older

C27 ANY OF THE FOLLOWING ABNORMAL BEHAVIOURS OBSERVED?

If you observe any of the following behaviours provide full details in the section provided.

- Severely withdrawn
- Severely agitated
- Responding to non-observable external stimuli (voices/visions)
- Deliberate self-harm.

For the questions C28-C32, ask the client the question observing their response to the questions. If the client answers 'Yes' to any of the questions, provide full details.

C28 HAVE YOU EVER BEEN HOSPITALISED OR TREATED FOR A MENTAL HEALTH PROBLEM OR HAVE YOU EVER BEEN SUICIDAL?

C29 DO YOU HAVE BAD MEMORIES ABOUT VIOLENCE OR OTHER EVENTS WHICH WON'T LEAVE YOU AND IF SO, HOW MUCH DO THEY GET IN THE WAY OF YOU BEING ABLE TO UNDERTAKE YOUR DAILY RESPONSIBILITIES OR ACTIVITIES?

C30 HAVE YOU EVER BELIEVED THAT SOMEONE WAS READING YOUR MIND, CONTROLLING YOUR MIND OR COULD PUT THOUGHTS IN YOUR MIND?

C31 HAVE YOU EVER HEARD THINGS SUCH AS VOICES COMING FROM OUTSIDE OF YOUR HEAD AND IF SO, WHAT DO THEY SAY?

C32 DO YOU HAVE THOUGHTS OF DEATH OR WISHING TO DIE WHICH DO NOT GO AWAY?

For clients under 15 years

If the answer to any of the following questions is 'Yes', provide full details.

C33 ANY SOCIAL WITHDRAWAL OR BEHAVIOURAL DISTURBANCE OBSERVED?

C34 IS YOUR CHILD EXTREMELY WITHDRAWN OR AGGRESSIVE A LOT OF THE TIME?

C35 ARE YOU VERY CONCERNED WITH THEIR BEHAVIOUR IN ANY OTHER WAY?

C36. HAS YOUR CHILD WITNESSED OR BEEN DIRECTLY EXPOSED TO VIOLENCE AND/OR SIGNIFICANT LOSS?

C37 HAS THIS RESULTED IN ABNORMAL BEHAVIOURS?

Other medical conditions present

C38 ARE ANY OF THE FOLLOWING PRESENT

Indicate in the boxes provided all the conditions that are present. If the condition is not listed, mark 'Not categorised' and provide details.

Pregnancy

C39 IS THE CLIENT PREGNANT?

This is a mandatory question for all non-males over 6 years of age.

C40 ESTIMATED DATE OF DELIVERY

If the client has a letter from their own doctor or lead maternity carer (obstetrician) confirming their pregnancy, scan and attach it to the health case. Record date in section provided.

SECTION D: CHEST X-RAY AND TB SCREENING

If abnormalities consistent with TB found on Chest X-ray and TB screening, email RHLT@mbie.govt.nz as soon a possible to enable prescription of further tests and assessments.

Questions D1 to D3 are to be answered for clients aged 11 years and older.

For clients under the age of 11, go to questions D4 to D10.

D1 IS A REPEAT X-RAY REQUIRED

A chest x-ray is required if the last screening chest x-ray was taken ≥ 6 months ago.

D2 DATE OF X-RAY

D3 RESULT

If results abnormal, provide details in full.

TB SCREENING FOR UNDER 11 YEARS OF AGE

D4 IS TB SCREENING REQUIRED

TB screening is required if the last test was done ≥ 6 months ago.

D5 EXAM DATE

This is the date that the blood is taken or the test is applied.

D6 TYPE OF EXAM CONDUCTED

For children aged<2 years, do a Tuberculin Skin Test (TST). For children aged 2-11 years, do a Interferon Gamma Release Assay (IGRA). Indicate which type

of test was used. For Tuberculin Skin Test (TST), answer questions D7 and D8. If Interferon Gamma Release Assay (IGRA), proceed to questions D9 and D10.

D7 IF TUBERCULIN SKIN TEST (TST)

Record the date of the test reading.

D8 IF TUBERCULIN SKIN TEST (TST)

Must be recorded in millimetres.

D9 IF INTERFERON GAMMA RELEASE ASSAY (IGRA) IS SELECTED

Indicate which type of IGRA used.

D10 RESULT

If result was not 'Negative', provide full details.

SECTION E: LABORATORY TESTS

Physicians should perform specimen collection onsite. If the physician delegates this procedure to a nurse or phlebotomist, the physician remains accountable for the integrity of the procedure. For further information about specimen integrity, please refer to *New Zealand Immigration Panel Member Instructions (INZ 1216)*.

The physician must select trusted laboratories to perform the tests required by INZ.

The physician must discuss the nature of testing with the client, or if the client is a person under 18 years of age or an incapable person, with the client's parent or guardian. Where applicable the physician should explain:

- standard tests that are advised as a part of the Departure Health Check
- the nature and reason for any discretionary tests
- that all test results will be provided to INZ

It is compulsory to record and attach results for all laboratory tests. When reviewing the laboratory tests, ensure that the person collecting the blood, and/or receiving the laboratory specimens has confirmed the client's identity to confirm that the samples were collected from the individual identified on the settlement health form.

Each of these tests requires a number value or 'nonreactive/reactive' response by the physician. The laboratory reference standard ranges for each test must be included in the results. Where the test(s) is serological for antibodies or antigens, the laboratory test used must also be specified.

eMedical: ***949 Departure Health Check***– Referral forms for laboratory tests can be generated using standard eMedical functionality. Please refer to the training guides within eMedical (module 9 – Examinations, section 9.6 Pathology and Other examinations) for more information if required.

Paper: ***Departure Health Check (INZ 1262)*** – A laboratory referral form (Section M) is included and comprises two pages to be detached and given to the client to take to the laboratory for completion. The physician is to sign and date the form including adequate address details where the results and the completed 'Section N: Confirmation of identity and declaration' are to be returned.

Please provide these pages of the form to the client along with directions to the laboratory. A separate laboratory referral form should be provided for each set of laboratory tests.

It is acceptable for physicians to use their own laboratory forms/process, with the proviso that 'Section N: Confirmation of identity and declaration' is still completed at the time of specimen collection, by both the client and the person collecting the specimens.

Laboratory reports must be initialled on each page and securely attached to the health form.

Abnormal laboratory test results

If a client's laboratory test results are abnormal, the physician should arrange additional testing as indicated below and seek advice from the RHLT at RHLT@mbie.govt.nz.

The following points need to be covered in discussion with the client where applicable, bearing in mind local ethical standards and requirements:

- Information about the tests and results
- Implications and possible prognosis
- Ways of transmission of the organism/s
- Ways of protecting others from infection with the organisms, in particular, the vaccination of close contacts of hepatitis B carriers
- Ways of minimising future complications
- Referral for medical intervention as discussed with RHLT. The physician is to detail any referral in the Laboratory Test 'Remarks' field.

Standard laboratory tests

The standard laboratory tests are not usually required as part of a departure health check.

However, additional laboratory tests are routinely requested on a Settlement Additional Information prescription when a Departure Health Check is prescribed. These are tailored to the client but will generally include:

- Full Blood Count
- Ferritin
- Sodium, Potassium, Creatinine and eGFR
- Calcium
- Liver Function Tests
- Vitamin D.

Discretionary laboratory tests

The physician should consider additional tests in any age group, due to indications from the medical history or physical examination findings, or known local conditions and risks (e.g. the local risks of Trypanosoma cruzi for Latin America and Spain). HIV testing for children <15 years of age is strongly recommended if their mother is HIV positive or if the child has history of blood or blood product transfusion. Discuss discretionary laboratory tests with RHLT at RHLT@mbie.govt.nz before undertaking.

Below is guidance for follow up of abnormal results for common discretionary laboratory tests. Tests recommended as part of this guidance can be organised without discussing with RHLT. Any other follow up tests need to be discussed with RHLT at RHLT@mbie.govt.nz before undertaking.

Test	Follow up of abnormal results
Estimated glomerular filtration rate (eGFR) in mL/min/1.73m2	› Ensure the client is well hydrated and repeat. › Where eGFR is not available, creatinine clearance must be done (involves 24-hour urine collection).
HIV positive	Add confirmatory tests such as Western Blot test or line-blot test.
Full blood count The following tests are required: Hb – haemoglobin in g/L WCC – total white cell count cells x 109/L PLATS – platelet count cells x 109/L	If abnormal result, repeat test after a period for two weeks for trend. If abnormality is low haemoglobin, add ferritin test when doing repeat testing. If significantly abnormal result, discuss with RHLT. Enter values as whole numbers with the exception of the White Blood Cells which should be recorded to one decimal place.
Liver function tests. Should include: › total bilirubin › alkaline phosphatase › AST – aspartate aminotransferase (SGOT) › ALT – alanine aminotransferase (SGPT) › GGT – gamma glutamyltransferase › Albumin › total protein	If abnormal, discuss further testing with RHLT.
Lipids These do not need to be fasting lipids. A full Lipid Profile should be provided: Total cholesterol; LDL; HDL; Triglycerides; Chol:HDL ratio.	Repeat testing not routinely required. Discuss with RHLT if concerns.

SECTION F: TRAVEL REQUIREMENTS

F1 ESCORT REQUIRED?

Mark the appropriate box. If yes is selected answer all questions from F2-F8.

If answered 'No', proceed to F9 (leaving question F2-F8 unanswered).

F2 ESCORT DESTINATION

Indicated from boxes how long escort required for.

F3 ESCORT TYPE

Indicate what type of escort is required. If a doctor is needed, provide details of specialisation.

F4 MEDICAL CONDITION(S) REQUIRING ESCORT

Indicate in the boxes all the conditions that the escort is required for. If the reason is not in the list provided, mark 'Not Categorised' and provide details in F5.

F5 EXACT MEDICAL CONDITION

Provide details of exact reason why escort required if not listed in the examples in F4.

F6 EXACT COST OF ESCORT

Provide details of cost of the escort with documentation to support this if you have it.

F7 ESCORT NAME IF KNOWN

Provide full name and position, if applicable.

F8 SUPPORT THE ESCORT WILL PROVIDE DURING TRAVEL

Provide details of what the role of the escort is during travel.

F9 –F13

Questions F9-F13 relate to personal travel requirements. Answer all questions.

F9 WHEELCHAIR

F10 SEATING

F11 IV RX

F12 AIR-LIFT

F13 OXYGEN

F14-F17

Questions F14-F17 relate to oxygen requirements. If oxygen is not required in F13, proceed to F18.

F14 FLOW

F15 DELIVERY

F16 TO

F17 WHILE

F18 OTHER REQUIREMENTS

Record any other assistance client needs during travel.

F19 DEPARTURE DATE

Provide date of flight if known.

F20 IS THERE ANY MEDICAL CONDITION THAT WILL DELAY TRAVEL?

If 'Yes', answer questions F21 and F22. If 'No', proceed to Section G of form.

F21 ANTICIPATED REVISED TRAVEL DATE

F22 REASON FOR DELAY

Provide reasons for the delay and what will be happening, if anything, during this time.

SECTION G: POST – ARRIVAL REQUIREMENTS

This section is to help the RHLT in planning of any future health services or community assistance that may be needed to aid resettlement and make plans for services to be provided.

G1 WILL THE CLIENT HAVE MEDICAL REQUIREMENTS ON ARRIVAL

If the answer is 'Yes' to G1, continue with questions G2-G4. G5 enables documentation of any other requirements the client may have that isn't covered by G2-G4.

If the answer is 'No' to G1, proceed to G6.

G2 AMBULANCE AT THE AIRPORT?

G3 HOSPITALISATION

G4 SURGERY

G5 OTHER REQUIREMENTS

RECOMMENDED MEDICAL FOLLOW UP ON ARRIVAL

G6 IS MEDICAL FOLLOW UP REQUIRED

If the answer is 'Yes', continue with questions G7-G10. G9 enables documentation of the details of what is required.

If the answer is 'No' for G6, proceed to Section H.

G7 URGENCY

G8 CASE PROVIDER

G9 DETAILS

G10 DURATION

SECTION H: PERSONAL REQUIREMENTS

This section helps facilitate any arrangements required for the client when they come to NZ, to ensure the appropriate support and services are available and ready to manage health needs.

Answer all questions in this section indicating the appropriate answer in each question. If you answer yes to any question from H2 to H7, provide further detail of assistance required in question H8. If the person requires assistance and it is not covered in the questions H2 to H7, use H9 to provide details of what assistance is required including the reason for the requirement and duration.

H1 WILL THE CLIENT NEED ASSISTANCE WITH PERSONAL CARE, HOUSING, SCHOOLING OR EMPLOYMENT?

H2 PERSONAL CARE

H3 AMOUNT OF ASSISTANCE REQUIRED

H4 MOBILITY PROBLEMS, ACCOMMODATION WITHOUT STAIRS

H5 WHEELCHAIR ACCESS

H6 OXYGEN

H7 SCHOOLING / EMPLOYMENT

H8 PROVIDE DETAILS

H9 OTHER NEEDS

SECTION I: SETTLEMENT VACCINATIONS

The questions in this section are for providing an accurate record for any vaccines that have been provided by your clinic.

Offer vaccinations according to New Zealand's Immunisation Schedule www.immune.org.nz/new-zealand-national-immunisation-schedule.

If required, continue catch up schedule of vaccinations. Follow guidance from Immunisation Handbook: Planning Immunisation Catch-Ups in the New Zealand Immunisation www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Record all vaccines given.

For further information about vaccinations, see the New Zealand Immunisation Handbook 2020 www.health.govt.nz/our-work/immunisation-handbook-2020

Chapters of specific interest include:

Planning Immunisation Catch-Ups in the New Zealand Immunisation
www.health.govt.nz/our-work/immunisation-handbook-2020/appendix-2-planning-immunisation-catch-ups

Immunisation of special groups

https://www.health.govt.nz/our-work/immunisation-handbook-2020/4-immunisation-special-groups including pregnancy and lactation, immunocompromised individuals, chronic kidney disease, chronic liver disease.

Processes for safe immunisations
www.health.govt.nz/our-work/immunisation-handbook-2020/2-processes-safe-immunisation which covers pre-vaccination screening in 2.1.3, with condition or circumstance to screen for (e.g. is pregnant, has a disease that lowers immunity), what actions to take and the rationale for this. This chapter also covers contraindications in 2.1.4 and post-vaccine advice in 2.3.1.

I1 EXAM DATE

Record the date the exam was completed.

I2 CONTRAINDICATIONS

Provide details of any contraindications.

I4 DISEASE / VACCINE:

Provide the name of the vaccine given.

Administered by clinic: (must be completed).

Batch number: As displayed on vaccine vial (must be completed).

Batch expiry: As displayed on vaccine vial (must be completed).

Route: Mark which route used (must be completed).

Waiver reasons: Only mark if any applies (can be left blank).

I5 MEASLES, MUMPS, RUBELLA, HEPATITIS B, POLIO & VARICELLA

Test for immunity positive

Record if test for immunity was previously done and date of test. If more than one immunity test was done, supply all records. There is no need to arrange immunity tests if not previously done.

I6 VARICELLA

Has the client had the disease? Document if the client has a history of having Varicella. Indicate yes or no.

SECTION J: SETTLEMENT MEDICATIONS

This section should be completed by the examining Physician. Answer all questions.

J1 EXAM DATE

Record the date of exam

Parasite medication

J2 PARASITE TREATMENT GIVEN

Provide clients with medications for presumptive treatment of parasites as per CDC Guidelines for Overseas Presumptive Treatment of Strongyloides, Schistosomiasis and Soil-Transmitted Helminth Infections available at www.cdc.gov/immigrantrefugeehealth/guidelines/overseas/intestinal-parasites-overseas.html. Therapy does not need to be directly observed. Advise clients to take the provided medications 1-2 days prior to travel.

Please complete table with the medication (brand and generic), dose and date medication given.

If parasite medication not given, please answer questions J3-J4.

J3 PROVIDE REASON

Indicate reason why parasite treatment was not provided.

J4 PROVIDE DETAILS

If the answer to J3 is anything other than 'Not required', record details here.

Regular medication

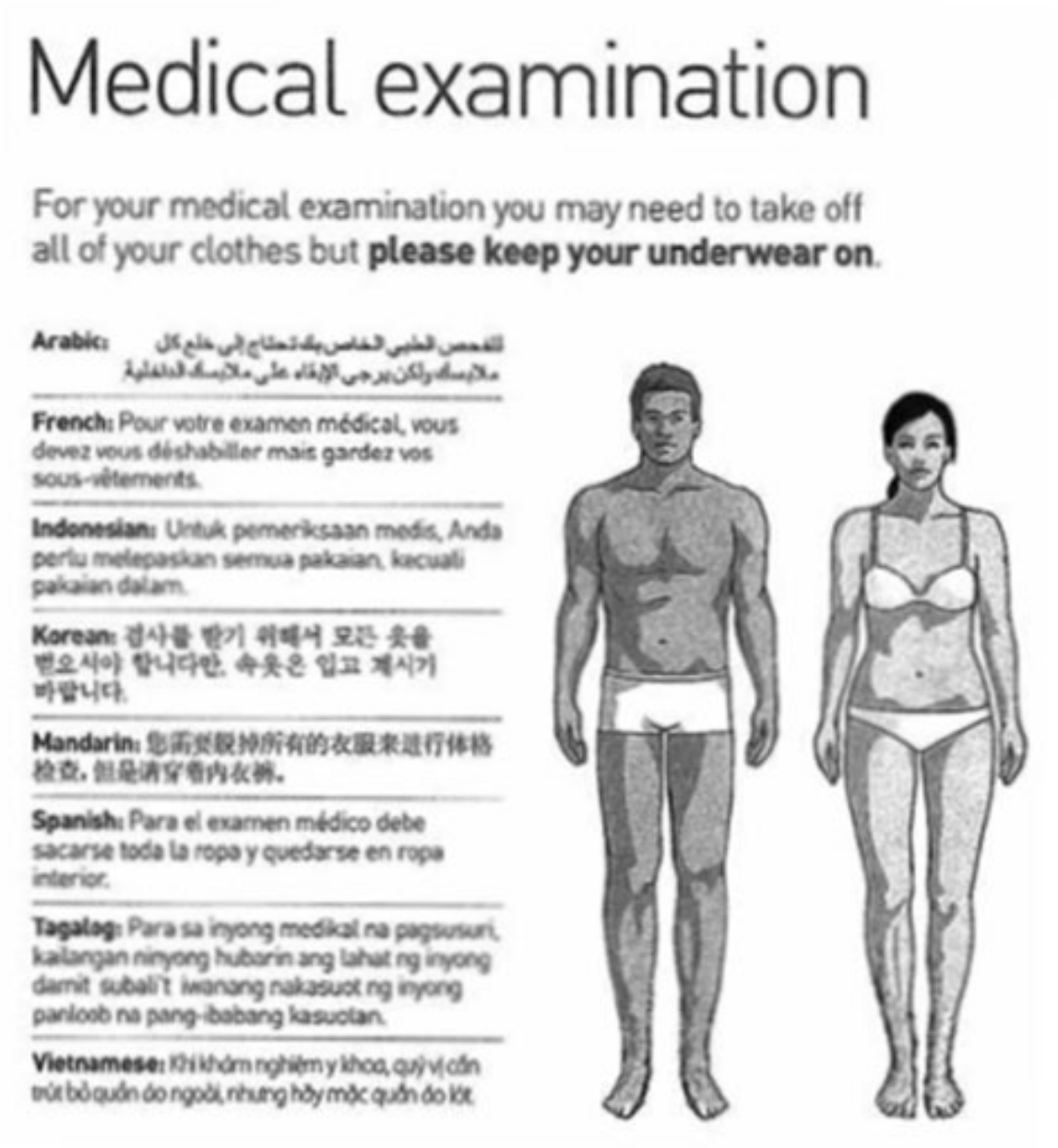
J5 HAS A FOUR-MONTH SUPPLY OF REGULAR MEDICATIONS BEEN GIVEN

If no, and is on medications, please provide details about why four-month's supply of medications is not provided.

If yes, provide a complete list of all medications including contraceptives, over the counter medications and natural supplements, with their doses and frequency. Complete the table with the medication (brand and generic), dose, quantity supplied, frequency and date given.

APPENDIX

APPENDIX 1: UNDRESSING FOR A SETTLEMENT HEALTH PHYSICAL EXAMINATION



From Australian Panel Members Instructions:
https://immi.homeaffairs.gov.au/support-subsite/files/panel-member-instructions.pdf

APPENDIX 2: ACTIVITIES OF DAILY LIVING INDEX (ADL)

Applicant's name:			Applicant's DOB:	
Self-care	**Intact**	**Limited**	**Helper**	**Unable**
	Note performance without help		**Note degree of assistance**	
	With ease, no devices or prior preparation	With difficulty or with devices or prior preparation	Some help	Totally dependent
Food/drink	☐	☐	☐	☐
Dress upper body	☐	☐	☐	☐
Dress lower body	☐	☐	☐	☐
Puts on brace/prosthesis	☐	☐	☐	☐
Wash/bathe	☐	☐	☐	☐
Perineum (at toilet)	☐	☐	☐	☐
Sphincters' control	☐	☐	☐	☐
	Note control without help		**Note frequency of accident**	
	Complete voluntary	Control but with urgency, or use of catheter, appliance	Occasionally some help needed	Frequent or often wet/ soiled
Bladder control				
Bowel control				
Mobility/locomotion	**With ease, no devices or prior preparation**	**With difficulty, or with device or prior preparation**	**Some help needed**	**Totally dependent**
Transfer bed	☐	☐	☐	☐
Transfer Chair/wheelchair	☐	☐	☐	☐
Transfer toilet	☐	☐	☐	☐
Transfer bath/shower	☐	☐	☐	☐
Transfer car	☐	☐	☐	☐
Walk 50 metres – level	☐	☐	☐	☐
Stairs, up/down one floor	☐	☐	☐	☐
Walk outdoors – 50 metres	☐	☐	☐	☐
Wheelchair – 50 metres	☐	☐	☐	☐
NB: In the context of the functional assessment, devices include such aids as feeding-cuffs, special cutlery dishes, dressing-aides, transfer boards/poles.				
	Full	**Moderate**	**Minimal**	**None**
Communication	☐	☐	☐	☐
Comprehension	☐	☐	☐	☐
Expression	☐	☐	☐	☐
Social cognition	☐	☐	☐	☐
Social interaction	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Current residence				
Own home ☐	Relative's home ☐	Personal care ☐	Hospital ☐	Other (please specify) ☐
Time at above:	Years:		months:	
Current caregiver Designation				
Printed name and signature of examining physician			Date (dd/mm/yyyy)	

From *Australian Immigration Panel Member Instructions*

APPENDIX 3: CHILD DEVELOPMENT MILESTONES GUIDELINES

This is one of the most difficult parts of any examination, especially if you have never met the child before and the child is anxious. Much can be achieved by observing the child: talking to the parents/guardians and having the child perform some simple tasks. These are average dates for the milestones

	Milestones given
Gross motor	
Chin up	1 month
Lifts head	4 months
Rolls - prone to supine	4 months
Rolls - supine to prone	5 months
Sits unsupported	8 months
Pulls to stand	9 months
Cruises	10 months
Walks alone	13 months
Walks up stairs	20 months
Rides tricycle	36 months
Hops on one foot	60 months
Fine motor	
Unfisting	3 months
Reach and grasp	5 months
Transfer	6 months
Thumb-finger grasp	9 months
Tower of two cubes	16 months
Handedness	24 months
Scribbles	24 months
Tower of four cubes	26 months
Tower of eight cubes	40 months
Social/self help	
Social smile	6 weeks
Recognises mother	3 months
Stranger anxiety	9 months
Finger feeds	10 months
Uses spoon	15 months
Uses fork	21 months
Assists with dressing	12 months
Pulls off socks	15 months
Unbuttons	30 months
Buttons	48 months
Ties shoelaces	60 months
Dresses without supervision	60 months

	Milestones given
Cognitive	
Shows anticipatory excitement	3 months
Plays with rattle	4 months
Plays peek-a-boo	8 months
Finds hidden object	9 months
Pulls string to obtain toy	14 months
Activates mechanical toy	20 months
Pretend play	24 months
Seeks out others for play	36 months
Expressive language	
Coos	3 months
Babbles	6 months
Da-da - inappropriate	8 months
Da/Ma - appropriate	10 months
First word	11 months
Two to six words	15 months
Two-word phrases	21 months
Speech all understandable	27 months
Names one colour	30 months
Uses plurals	36 months
Names four colours	42 months
Gives first and last names	44 months
Names two opposites	50 months
Strings sentences together	60 months
Receptive language	
Gesture games	9 months
Understands 'no'	9 months
Follows one-step command	12 months
Points to animal pictures	19 months
Points to six body parts	20 months
Follows two-step command	24 months

(Development guidelines drawn from General Practice, 3rd edition, John Murtagh, Mcgraw-Hill, Sydney, 2003)