Washington State Domestic Medical Examination Guidelines
Federal Fiscal Year 2025

The Washington State Domestic Medical Examination Guidelines are based on the Centers for Disease Control and Prevention's (CDC) Guidance for the U.S. Domestic Medical Examination for Newly Arriving Refugees, the Office of Refugee Resettlement (ORR) Domestic Medical Screening Guidelines Checklist, and WA Department of Health subject matter experts' recommendations. The domestic medical examination is an opportunity to identify health issues, promote well-being, orient new arrivals to the US healthcare system, and connect refugees and other humanitarian entrants with ongoing care.

This document provides guidance for clinicians contracted to provide the domestic medical examination in Washington state. Clinical judgment and local risk factors should be used when implementing these guidelines.

Key Considerations

Medical interpretation

- Professional medical interpreters should be provided in-person or using a professional remote interpreter service (phone or video) for any patient who speaks a primary language other than English. If unable to find an interpreter for a specific language at the initial encounter, re-evaluate interpreter availability at each subsequent encounter. The Office of Minority Health's Think Cultural Health website provides many resources and educational opportunities for healthcare professionals to learn about culturally and linguistically appropriate services (CLAS). Review the Working Effectively with an Interpreter checklist for steps to improve interpreter, healthcare professional, and patient interactions.

Gender Concordance

- Patients may prefer to work with a healthcare professional of their own gender. This may include interpreters, medical assistants, and nurses. If adequate staffing is available, such requests should be honored.

Consent and Confidentiality

- Review consent, confidentiality, and limits to confidentiality (e.g., mandatory reporting) with patients at the beginning of the first visit in the patient's preferred language. This overview should include a discussion of who can access medical records and health information, and adult patients' rights to make their own healthcare decisions.
- It is important to explain that confidentiality extends to ancillary staff (including interpreters and social workers). Providers and support staff are not permitted to share any health information with community members.

History and Physical

- Review overseas medical records and note any concerns mentioned.
- During the initial screening appointment, address immediate health concerns and obtain a detailed history, including aspects unique to refugees (e.g., travel history).
- Perform a review of systems, considering the risk for particular infections and illnesses the patient may have based on family medical history, occupational history, travel history, and country of origin.
- Provide vision screening (≥3 years) and hearing screening (≥4 years)
- Measure height, weight, and head circumference (if ≤24 months old).
- Inquire about drug, alcohol, and tobacco use or secondhand smoke exposure. Keep in mind culturally specific substances of abuse (e.g., Betel quid/areca nut, Khat). Counsel or refer the individual if screening determines a significant substance use addiction.

Nutrition and Growth

- Document overseas anthropometric indices, if available.
- Assess dietary history including habits, restrictions, and cultural dietary norms; food allergies; and known current and past nutritional deficiencies.
- Provide basic nutritional screening to identify nutritional deficiencies that require further evaluation and/or treatment.
- Measure anthropometric indices to characterize potential malnutrition:
  - Weight-for-Height,
  - Height-for-Age, and
  - Weight-for Age (children)
- Body mass index (BMI) calculation (children older than 2 years and all adults)
- For children younger than 2 years of age, growth indicators should be compared to WHO standardized growth references while Center for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS) references may be used for those over 2 years of age.
- Examination for specific physical findings indicating undernutrition/ overnutrition or micronutrient deficiencies
- Population-specific testing may be performed based on clinical discretion (e.g., vitamin B12 deficiency in Bhutanese refugees)
- Prevention and Counseling:
  - Refer all children <5 years and pregnant people to WIC
  - Children with clinical or laboratory evidence of poor nutrition may benefit from a multivitamin or specific supplementation according to published standards of practice (e.g. vitamin D). Still, research in this area suggests most deficiencies will improve when the child is encouraged to eat a broader and more diverse diet.

Mental Health Screening

- Review overseas records for documentation of:
  - type and severity of any trauma/abuse
  - physical and mental disorders with associated harmful behaviors
  - substance-related disorders
- Perform mental health screening:
  - Refugee Health Screener 15 (RHS-15) per Pathways to Wellness guidelines for all individuals 14 years or older.
- Refer for follow-up based on screening exam findings using CDC's referral best practices.
- For children with concerns for developmental delay or other behavioral health concerns, refer for further evaluation through pediatrician or family primary care.

Complete Blood Count with Differential

- Perform complete blood count with red blood cell indices, white blood cell differential, and platelet count for all adults and children.
- Inherited hematologic disorders (e.g., thalassemias, sickle cell disease, and enzyme or cell membrane defects) should be considered in any newcomer with anemia detected on screening, particularly if not corrected with therapy. Those with a Mentzer Index (MCV/RBC) <13 should be evaluated for beta thalassemia trait to include HbA_2 electrophoresis. Patients with beta thalassemia and concomitant iron deficiency can have normal HbA_2 levels so iron deficiency should be treated prior to electrophoresis testing. Consider screening for hemoglobinopathies in children from high-prevalence areas. More information is in the Newborn Screening section.
- Eosinophilia (absolute eosinophil count >400 eosinophils/mm^3) in a newly arrived refugee likely indicates recently treated or current parasitic infection. Refer to primary care for repeat eosinophils in 3-6 months to ensure resolution. See Presumptive Treatment and Medical Screening for Parasites in Newly Arriving Refugees for more information.

Sexual and Reproductive Health Screening

Pregnancy Testing

- A urine pregnancy test should be performed for all women of childbearing age and pubescent adolescent girls.
- Repeat a pregnancy test if date of last unprotected sex is within 14 days and the first test was negative (if menses is not reported since last unprotected sex).
- Refer pregnant individuals for ongoing care, as appropriate.

Family Planning and Contraception

- Refer to primary care to discuss family planning and available contraceptive methods. Condoms should be available at the refugee health screening examination to avoid unintended pregnancy and sexually transmitted infections (STIs).

Syphilis Screening and Confirmatory Testing

Screening tests should be performed routinely for refugees in the following categories:

- All refugees 15 years and older, if no pre-departure results are available.
- Refugees younger than 15 years of age who are at risk for congenital syphilis (i.e., birthing parent tests positive for syphilis, if the birthing parent's syphilis results are not available, or the child is unaccompanied), who disclose sexual activity, or have been sexually assaulted should be evaluated according to the CDC Sexually Transmitted Diseases Treatment Guidelines, 2021.
- Testing of refugees with pre-departure results available may be considered based on risk factors or local health jurisdiction recommendations.
- Ensure confirmatory testing is performed if a refugee screens positive for syphilis. In Washington, all reactive serologies for syphilis (non-treponemal and treponemal) must have a subsample submitted to the Washington State Public Health Laboratory for a confirmatory test.
- See this CDC Table for interpretation of syphilis serology tests.
- Notify local health jurisdiction per chapter 246-101 WAC.

Chlamydia and Gonorrhea Screening (nucleic acid amplification tests)

- All refugees aged 15 years and older, if no pre-departure results are available.
- Children younger than 15 years should be tested if there is a history of chlamydia or reason to suspect infection.
- Test any refugees with abnormal vaginal, penile, or rectal discharge, intermenstrual vaginal bleeding, dysuria, or lower abdominal, rectal, or pelvic pain.
- Notify local health jurisdiction per chapter 246-101 WAC.

Newborn Screening Tests

- All children under 6 months of age should receive full newborn screening.
- For older children with unexplained symptoms of abnormal or developmental delay, consider a newborn screening panel.
- Washington State Office of Newborn Screening recommends that all children ≤17 years of age receive a hemoglobin screening for sickle cell and other hemoglobinopathies.
- All newborn screening tests, including screening for hemoglobinopathies, can be done through the Washington State Public Health Laboratories, even for children over 6 months old, however, results for children > 1 year may be less reliable. **Please note in the miscellaneous information box that the child was born outside of the U.S. to let newborn screening staff know that the child may not have had newborn screening in their country of birth when sending samples to the Washington State Public Health Lab.**
- Congenital and iodine-deficient hypothyroidism should be considered in all infants and children <6 years of age. Thyroid-stimulating hormone (TSH) and free T4 should be used when screening for thyroid disease.

Blood Lead Level Screening

- Perform blood lead level (BLL) test for all children ≤ 16 years.
- Perform blood lead level testing for all pregnant and lactating people.
- Perform blood lead level test for children > 16 years old if there is a high index of suspicion or clinical signs/symptoms of lead exposure.
- Repeat testing by the primary care provider is recommended within 3–6 months after initial testing is recommended in the following groups:
    - All refugee infants and children ≤6 years of age, *regardless of initial screening BLL result*.
    - Children and adolescents 7-16 years old who had EBLL of ≥ 5 µg/dL at initial screening and for any child older than 7 years old who has a risk factor (e.g., sibling with BLL at or above 5 µg/dL, environmental exposure risk factors) regardless of initial test result.
    - Pregnant and lactating people whose BLL is at or above 5 µg/dL upon initial screening. Repeat testing should also be considered in pregnant or lactating people <18 years of age who had BLLs at or above 3.5 µg/dL at initial screening. The frequency of follow-up and actions taken are dependent on the BLL (See Clinical Management of Lead Exposure in Pregnant and Lactating Women and the Breastfed Infant, PEHSU). Referral to a healthcare provider with expertise in lead exposure treatment may be indicated.
- In any case of a symptomatic child with a confirmed EBLL >44 µg/dL, contact NW PEHSU or Poison Control Center (1-800-222-1222) for consultation and assistance.
- Notify the WA Department of Health per chapter 246-101 WAC.

HIV Testing

- Use HIV antigen/antibody testing methods for screening. **Quantitative HIV RNA NAA (e.g., RT-PCR) tests are not appropriate for HIV screening. Qualitative** HIV RNA NAA tests may be used if acute HIV infection is suspected in antibody-negative individuals.
- Perform HIV testing for all individuals 13 – 64 years of age.
- Children ≤ 12 years of age should be screened unless negative HIV status for the birthing parent **can be confirmed** and the child is otherwise considered at low risk of infection (e.g., no transfusion, the birthing parent is not living with HIV, not sexually active). Children <18 months of age who test positive for HIV antibodies should receive further testing with DNA or RNA assays. Results of positive antibody tests in this age group can be unreliable because they may detect persistent maternal antibodies.
- All children born to or breast/chest-fed by a person living with HIV should receive chemoprophylactic trimethoprim/sulfamethoxazole beginning >6 weeks of age until they are confirmed to not be living with HIV themselves.
- Screening all other refugees is also encouraged unless they decline (opt-out). Separate and exceptional consent for HIV testing is not required.
- Repeat screening through primary care 3-6 months following resettlement is recommended for refugees with a recent exposure or risk of acquiring HIV to identify individuals who may be in the "window period" when they arrive in the United States.
- Refer those testing positive for HIV for follow-up testing and medical care.
- All positive HIV antigen/antibody tests should reflex to confirmatory testing such as an HIV 1/2 antibody differentiation assay and/or qualitative HIV-1/2 HIV RNA NAA testing.
- Notify local health jurisdiction per chapter 246-101 WAC.

Viral Hepatitis Screening

Routine screening for Hepatitis A, D, & E is not recommended, however, general hepatitis screening panels typically include hepatitis A antibody testing. Hepatitis A vaccination is recommended for children and select adults following ACIP recommendations.

Hepatitis B

- Review overseas documentation for hepatitis B vaccination doses administered and testing for HBsAg.
- All newly arriving refugees, including children and pregnant people, should receive HBsAg testing. However, HBsAg testing should be delayed for at least 4 weeks after the most recent hepatitis B vaccination because the vaccine can cause a false positive HBsAg for up to 30 days.
- In addition, for those who are unvaccinated/incompletely vaccinated, or for which predeparture vaccination validity is in question, consider also ordering hepatitis B surface antibody (anti-HBs) and total hepatitis B core antibody (anti-HBc) testing to assist in determining immune status and the need for hepatitis B vaccination (see table below).
- Those who do not have HBV infection or evidence of immunity from natural infection and are unvaccinated or have incomplete vaccination should be offered the hepatitis B vaccination series according to ACIP recommendations. See the CDC table in Appendix A for interpretation and initial management guidance.
- Refer individuals with hepatitis B infection for follow-up, **including testing for hepatitis D**.
- Notify local health jurisdiction per chapter 246-101 WAC.

Hepatitis C

- Initial hepatitis C screening should include testing for hepatitis C virus total antibody (anti-HCV). Samples with an anti-HCV positive result should have reflex testing with an HCV nucleic acid test (NAT).
- Screen all:
  - adults (≥18 years of age)
  - pregnant individuals during each pregnancy
  - unaccompanied refugee minors
  - children with risk factors for hepatitis C, including blood transfusion receipt, HIV infection, or birthing parent with known hepatitis C infection. **NOTE**: HCV NAT testing is recommended, instead of anti-HCV, if testing a child < 18 months old.
- Refer individuals with hepatitis C infection for follow-up, including vaccination for hepatitis A and hepatitis B if susceptible, and medical evaluation for monitoring and treatment.
- Notify local health jurisdiction per chapter 246-101 WAC.

Immunizations

- Vaccine doses administered outside the United States should be accepted as valid when documented and the schedules and doses are compatible with Advisory Committee on Immunization Practices (ACIP) recommendations. Check the WA Immunization Information System (WAIIS) for available refugee vaccination data that may have been transferred from overseas via the CDC's Refugee Immunization Information Systems Exchange (RIISE) project.
- Initiate, complete, or repeat vaccinations per ACIP's immunization schedule. Repeating the vaccinations is an acceptable option that is usually safe and prevents the need to obtain and interpret serologic tests.
- Serologic testing for immunity is an alternative for certain diseases (e.g., varicella, hepatitis A, hepatitis B, measles, mumps, and rubella virus) when the provider believes the refugee was likely to have had a previous infection that conveyed immunity or received a full series of vaccines but did not have documentation of vaccinations. For some vaccines, available serologic tests cannot document protection against infection. Review the ACIP guidance on possible approaches to evaluation and revaccination for each vaccine recommended in the US for more information.
- Record previous vaccines, lab evidence of immunity, or history of disease in the Washington State Immunization Information System.
- Language translations are available from the Immunization Action Coalition [PDF – 2 pages] and the CDC Pink Book. The Immunization Action Coalition also has published a list of vaccine manufacturers and product information.

Notes:

- TB testing (IGRA or TST) should be completed prior to or on the same day of administering any live virus vaccines or deferred for at least 28 days after vaccination.
- HBsAg testing should be delayed for at least 4 weeks after the final hepatitis B vaccination because the vaccine can cause a false positive HBsAg for up to 30 days. See the hepatitis B screening guidance in this document for more serology and vaccination guidance.
- HIV with moderate to severe immunosuppression (CD4 count < 200 µL) is a contraindication for certain live virus vaccines such as MMR and varicella. If there is clinical suspicion of immunosuppression from undiagnosed HIV/AIDS, then delay live virus vaccines until testing is performed and results are reviewed.

Tuberculosis (TB) Screening

- For all adults and children:
  - Review overseas records of TB testing and/or treatment.
  - Evaluate history of tuberculosis disease, exposure, and/or any treatment.
  - Assess signs or symptoms of disease.
- Dependent on age and overseas TB testing outcomes, screen for tuberculosis using a tuberculin skin test (TST) or interferon-gamma release assay (IGRA).
  - For children aged < 2 years, a TST is recommended.
  - Risk assessment may be used to inform screening in infants <6 months old.
  - For children ages 2 to 14 years:
    - If they had a negative IGRA < 6 months ago and no signs of TB disease, no further evaluation is needed.
    - If an IGRA was not performed or if they had a negative IGRA > 6 months ago, an IGRA is recommended.
  - For refugee arrivers ages 15 years and older, an IGRA is recommended if they had a normal chest x-ray prior to departure and an overseas IGRA was not performed, or the individual had a negative IGRA > 6 months ago.
- Vaccinations and IGRA or TST
  - Test for TB at the same encounter or prior to administration of live virus vaccines. There are no administration timing constraints with any inactivated vaccines and TB testing, including COVID vaccines.
- Perform PA chest x-ray (with lateral view for children <5 years old) and sputum testing as indicated to rule out active TB (e.g., patients with positive TB testing or symptoms of TB disease).
- All individuals with Class A or Class B TB classification should be evaluated for TB per local health jurisdiction TB program guidelines.
- Notify local health jurisdiction per chapter 246-101 WAC.

Malaria

- Evaluate overseas records for information regarding pre-departure treatment for malaria (sub-Saharan Africa only).
- Refugees from sub-Saharan Africa who received pre-departure treatment with a recommended antimalarial drug or drug combination no sooner than 5 days before departure do not need further evaluation or treatment for malaria unless they have signs or symptoms of disease.
- Subclinical *P. falciparum* malaria may be present in refugees from highly endemic regions of sub-Saharan Africa. If a refugee has been in a non-endemic region for more than 3 months, falciparum malaria is unlikely, though possible—symptomatic patients should be tested.
- Refugees originating from sub-Saharan Africa who have not received pre-departure therapy with a recommended regimen should receive presumptive treatment (CDC DME Guidelines, Table 1) or screening (not preferred in most cases) at the domestic medical visit, if within 3 months of arrival. **Presumptive treatment is contraindicated for the following groups:**
  - Pregnant women in their first trimester of pregnancy
  - Infants weighing < 5 kilograms (kg)
  - Those with a known allergy to the medication being used
- Refugees from areas *other than sub-Saharan Africa* are not routinely presumptively treated or tested, unless specifically directed. Refugees with signs or symptoms who have been in endemic areas should be evaluated promptly for malaria.
- Notify local health jurisdiction per chapter 246-101 WAC.

Strongyloidiasis, other soil-transmitted helminths and schistosomiasis

- Evaluate overseas records for information regarding pre-departure treatment and determine if the patient received complete presumptive treatment overseas.
- See Appendix B for a summary of CDC's presumptive treatment guidance.

Strongyloides

- Asymptomatic refugees who did not receive overseas presumptive ivermectin treatment may be presumptively treated at arrival, or screened ("test and treat") if contraindications to presumptive treatment exist or ivermectin is unavailable. If using a "test and treat" approach, include Strongyloides IgG serology. Stool O&P may also be done in conjunction but lacks sensitivity to rule out infection alone.
  - Refugees who have lived in a Loa loa-endemic country should be tested for Loa loa infection BEFORE receiving ivermectin. If Loa loa infection cannot be reasonably excluded or ivermectin is not readily available, high-dose albendazole (400 mg twice daily x 7 days) is an acceptable alternative per CDC's Clinical Care of Strongyloides guidelines.

Soil-transmitted helminths (STHs)

- Refugees who have received pre-departure treatment do not require further screening or testing for soil-transmitted helminths unless they have symptoms, or have signs of infection such as persistent eosinophilia.
- Asymptomatic refugees who did not receive overseas presumptive treatment may be presumptively treated upon arrival with a single dose of albendazole. Asymptomatic refugees can also be screened ("test and treat") if contraindications to presumptive treatment exist or albendazole is unavailable.
- If using the "Test and treat" approach for STHs it is generally done with two or more separate stool O&P tests done by concentration technique; samples must be collected 12 to 24 hours apart because shedding may be intermittent.
- Infants under 6 months old without a history of direct skin contact with soil or fecal-oral contact are at low risk of infection so testing is at the provider's discretion. Still, those with signs of infection (e.g., elevated eosinophil count) should be tested.

Schistosoma

- All sub-Saharan African (SSA) countries are considered endemic for schistosomiasis. Most refugees from SSA countries should have received pre-departure presumptive treatment with praziquantel.
- Asymptomatic SSA refugees who did not receive overseas presumptive praziquantel treatment may be presumptively treated after arrival, or screened ("test and treat") if contraindications to presumptive treatment exist or if praziquantel is unavailable or inaccessible.
- If using a "test and treat" approach include schistosoma IgG serology. Testing stool and urine for eggs and UA for RBCs may also be done in conjunction but lack sensitivity to rule out infection alone.
- Previous treatment will not decrease IgG levels so persistently positive results do not necessarily indicate a new infection and should not be used to monitor treatment success.
- Mothers with schistosomiasis are known to pass IgG to their infants. The duration of infant schistosoma IgG positivity from maternal-fetal transmission of immunoglobulins is unknown. Positive IgG results in infants should be interpreted in consultation with CDC experts. Unless an SSA infant has direct skin-to-fresh water contact, infection with Schistosoma species is relatively unlikely and testing is not recommended.
- Treatment is not 100% effective, and continuation of symptoms or signs of infection (e.g., ongoing eosinophilia) should prompt further investigation; repeat treatment may be necessary.

Appendix A

Interpretation of Hepatitis B Serologic Markers

Serologic Marker					Interpretation (I) & Initial Management (M)
	HBsAg	anti-HBc	IgM anti-HBc	anti-HBs	
Test Results	–	–	–	–	**I**: Never infected and susceptible to infection **M**: Recommend hepatitis B vaccination series according to ACIP recommendations
	+	+	–	–	**I**: Chronic HBV infection **M**: Obtain additional testing including HBV DNA, HBeAg, anti-HBe, and ALT, **AND** link to care; provide patient counseling related to chronic HBV infection
	–	+	–	+	**I**: Immune* following natural infection **M**: No additional vaccination needed for HBV, even if series was initiated pre-departure
	+	+	+	–	**I**: Acute HBV infection **M**: Refer for clinical assessment if symptomatic, otherwise recheck HBsAg 6 months after initial testing
	–	–	–	+	**I**: Immune* due to hepatitis B vaccination **M**: No action needed
	–	+	–	–	**I**: Various interpretations: 1. Resolved infection (most common in regions with intermediate or high endemicity) 2. Chronic infection with low viral load 3. Resolving acute infection **M**: Obtain additional testing including HBV DNA to rule out occult infection, **AND** link to care for follow-up and monitoring**

Source: https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/viral-hepatitis.html

Appendix B

Presumptive Treatment of Intestinal Parasites

	Presumptive Treatment		
Adults	**Treatment**	**Origin**	
		Asia, Middle East, North Africa[1], Latin America, and Caribbean	Sub-Saharan Africa
	Albendazole for Soil-transmitted Helminths	400 mg PO single dose	400 mg PO single dose
	Ivermectin for Strongyloidiasis	200 µg/kg PO single dose	200 µg/kg orally PO single dose **IF** from a non Loa loa-endemic country[2], **OR** high microfilarial load from Loa loa infection has been ruled out[3]
	Praziquantel for Schistosomiasis	Not recommended	40 mg/kg PO in single or divided dose
	Presumptive Treatment		
Pregnant People	**Treatment**	**Origin**	
		Asia, Middle East, North Africa[1], Latin America, and Caribbean	Sub-Saharan Africa
	Albendazole for Soil-transmitted Helminths	Not recommended	Not recommended
	Ivermectin for Strongyloidiasis	Not recommended	Not recommended
	Praziquantel for Schistosomiasis	Not recommended	40 mg/kg PO in single or divided dose
	Presumptive Treatment		
Children	**Treatment**	**Origin**	
		Asia, Middle East, North Africa[1], Latin America, and Caribbean	Sub-Saharan Africa
	Albendazole for Soil-transmitted Helminths	<12 months old: Not recommended 12-23 months old: 200 mg PO single dose >2 years old: 400 mg PO single dose	<12 months old: Not recommended 12-23 months old: 200 mg PO single dose >2 years old: 400 mg PO single dose
	Ivermectin for Strongyloidiasis	≤15 kg OR from Loa loa-endemic country[2]: Not Recommended 200 µg/kg PO single dose	≤15 kg OR from Loa loa-endemic country[2]: Not Recommended 200 µg/kg PO single dose
	Praziquantel for Schistosomiasis	Not recommended	<4 years old: Not recommended ≥4 years old: 40 mg/kg PO in single or divided dose

[1]North African countries: West Sahara, Morocco, Algeria, Tunisia, Libya, Egypt

[2]Loa loa-endemic countries: Angola, Cameroon, Central African Republic, Chad, Congo, Ethiopia*, Equatorial Guinea, Gabon, Nigeria, South Sudan, Democratic Republic of Congo

*Several areas of Ethiopia currently have endemic Loa loa. However, resettling refugees are not from these areas. Ethiopian refugees are receiving

[3]Management for Strongyloides in those at risk for Loa loa infection

Source: https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/intestinal-parasites.html

For more information please contact:

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