

NOTE: This form is to be used only for Significant Medical Conditions. If there is no apparent disease, serious medical condition, or need for follow-up care, please do not complete this form.

Significant Medical Conditions Form

Date:	Case No:	Name:	
Location (transit station):	Language(s):	Recommend expedite process on medical ground:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alien No:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth:	

Significant Medical Conditions:

1. Hearing:	<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired (needs hearing aid)	<input type="checkbox"/> Deaf
2. Vision:	<input type="checkbox"/> Normal	<input type="checkbox"/> Impaired (best corrected < 20/100)	<input type="checkbox"/> Blind
3. Learning/Development:	<input type="checkbox"/> Normal	<input type="checkbox"/> Needs special attention	<input type="checkbox"/> Not able/Dependent
4. Communicating:	<input type="checkbox"/> Normal	<input type="checkbox"/> Can be understood with difficulties	<input type="checkbox"/> Not able/Dependent
5. Mobility:	<input type="checkbox"/> Normal	<input type="checkbox"/> Can move with difficulties	<input type="checkbox"/> Not able/Dependent
6. Trauma/Injury:	<input type="checkbox"/> Normal	<input type="checkbox"/> Assistance required	<input type="checkbox"/> Not able/Dependent
7. Mental Health Condition:	<input type="checkbox"/> Normal	<input type="checkbox"/> Assistance required	<input type="checkbox"/> Not able/Dependent
8.		<input type="checkbox"/> Assistance required	<input type="checkbox"/> Not able/Dependent
9.		<input type="checkbox"/> Assistance required	<input type="checkbox"/> Not able/Dependent

Assistance Required for Personal Care and Housing Requirements:

<input type="checkbox"/> Fully independent, no assistance required <input type="checkbox"/> Minimal supervision for self-care required <input type="checkbox"/> Mobile/Assistance of 1 person required <input type="checkbox"/> Part-time <input type="checkbox"/> Full time <input type="checkbox"/> Immobile/Assistance of 2 or more persons required <input type="checkbox"/> Other adaptation/employment/educational needs, specify:	<input type="checkbox"/> Mobility problems, accommodation without stairs <input type="checkbox"/> Wheelchair access needed <p>Schooling/employment needs:</p> <input type="checkbox"/> Can attend school/hold a job <input type="checkbox"/> Needs special schooling/job arrangements <input type="checkbox"/> Unlikely to be able to attend school/hold a job
--	---

Medical Follow up After Arrival: NO YES

Urgency:	<input type="checkbox"/> Immediately	<input type="checkbox"/> In one week	<input type="checkbox"/> In one month	<input type="checkbox"/> In six months
Care Provider:	<input type="checkbox"/> Family physician	<input type="checkbox"/> Counseling/Psychotherapy	<input type="checkbox"/> Specialist, specify:	
Duration:	<input type="checkbox"/> Initial only	<input type="checkbox"/> Ongoing (specify if necessary):		

Medication Needs: NO YES, non injectables Yes, Medication Alert (injectables)

Current Medications: <i>please indicate both brand and generic names:</i>	Dose	Recommended supply upon arrival: Should not finish before the f/up medical appointment
1.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
2.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
3.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
4.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
5.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
6.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
7.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
8.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
9.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks
10.		<input type="checkbox"/> 2 wks <input type="checkbox"/> 4 wks <input type="checkbox"/> 8 wks <input type="checkbox"/> 12 wks

Comments:

NOTE: This form is to be used only for Significant Medical Conditions. If there is no apparent disease, serious medical condition, or need for follow-up care, please do not complete this form.

Medical Requirements upon arrival to Final Destination: NO YES

Ambulance (at the airport) Hospitalization Immediate Planned Surgery Extensive Non-extensive
Other, Specify:

Comments:

Travel Requirements: **Travel By Date:** **Reason:**

Pre-departure: Treatment Check Pregnant, EDD *dd-MMM-YYYY* Hospitalization
Escort Type: Individual(FD) Group(POE) Doctor Nurse Specialist: _____ Non-medical
Wheelchair: WCHR (Can Walk Up Stairs) WCHS (Not Able To Walk Up Stairs) WCHC (Carry-on Passenger)
In Flight: Extra seat 3 seats Bus. class Stretcher IVRx Air-lift Oxygen, at ___ LPM to FD POE
Disability code: BLND (blind) DEAF MED (medical case)
Other, specify:

Signature (Physician filling out form): _____

Additional comments:

Instructions:

The Significant Medical Condition (SMC) form is designed to provide a tool for collecting and transmitting advance information on refugees' post-arrival resettlement needs to receiving agencies in the country of destination. This form is required to be filled for any refugee diagnosed with medical conditions requiring additional assistance from the receiving side, based on, but not limited to the following criteria:

- Pregnancy;
- Requiring medical escort;
- With significant mobility problems requiring wheelchair, stretcher or special accommodation;
- Requiring medical follow up within one week or hospitalization upon arrival;
- Requiring extensive surgery or other extensive treatment (e.g. renal dialysis);
- Requiring external assistance in regular administration of injectable drugs;
- With special schooling, accommodation or employment needs;
- Requiring assistance of one or more persons in daily living activities such as:
 - With physical disability (amputees, paralyzed, cerebral palsies, etc...)
 - Severely impaired vision, communication or hearing;
- With significant mental illnesses and/or developmental delays.

The SMC form should be filled at completion of the initial health assessment and attached to other medical forms sent to the resettlement authorities of the receiving country. It is the policy of IOM to ensure these forms are recalled and properly updated in case of significant health changes revealed prior to a refugee's departure.

N.B. While filling the form, please keep in mind that audience of this form is non-medical staff of the Resettlement Agencies.