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: ☐ No ☐ Yes
Alien No:	Gender: ☐ M ☐ F	Date of birth:

Significant Medical Conditions:

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

Assistance Required for Personal Care and Housing Requirements:

☐ Fully independent, no assistance required
☐ Minimal supervision for self-care required
☐ Mobile/Assistance of 1 person required ☐ Part-time ☐ Full time
☐ Immobile/Assistance of 2 or more persons required
☐ Other adaptation/employment/educational needs, specify:

☐ Mobility problems, accommodation without stairs
☐ Wheelchair access needed

Schooling/employment needs:

☐ Can attend school/hold a job
☐ Needs special schooling/job arrangements
☐ Unlikely to be able to attend school/hold a job

Medical Follow up After Arrival: ☐ **NO** ☐ **YES**

Urgency: ☐ Immediately ☐ In one week ☐ In one month ☐ In six months

Care Provider: ☐ Family physician ☐ Counseling/Psychotherapy ☐ Specialist, specify:

Duration: ☐ Initial only ☐ Ongoing (specify if necessary):

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

Current Medications: *please indicate both brand and generic names*:	Dose	Recommended supply upon arrival: Should not finish before the f/up medical appointment
1.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
2.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
3.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
4.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
5.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
6.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
7.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
8.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
9.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks
10.		☐ 2 wks ☐ 4 wks ☐ 8 wks ☐ 12 wks

Comments:

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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.