Department of Health (Vic)	*General Practice Victoria*

Using Medical Director to complete the Refugee Health Assessment

Item Numbers 701, 703, 705 or 707

Notes to assist GPs, Nurses and Practice Staff to complete the assessment
September 07, updated June 2010.

ACKNOWLEDGEMENTS:
The refugee health assessment template was originally conceived by Dr. Joanne Gardiner (GP, Darebin CHC) and developed by the physicians at the Victorian Infectious Diseases Service, Dr. Beverley Biggs, tel. 8344 3257, www.mh.org.au/VIDS); Royal Children's Hospital Immigrant Child Health Clinic (RCH tel. 9345 5522); Victorian Foundation for Survivors of Torture and General Practitioners in the Northern and Western Divisions of General Practice, Melbourne.

This document contains modifications of the original health assessment template which are based on a number of sources, including but not limited to:

GPDV Refugee Health Assessment reference group members (Lenora Lippmann GPDV, Annette Dupont GPDV, Dr. Kate Walker GPDV, Associate Professor Beverley-Ann Biggs, Dr Joanne Gardiner, Dr I-Hao Cheng, Dr Georgia Paxton, Ms Marianne Eskander, Dr John Stanton)
Changes to the wording of the psychological screening questions proposed by Ida Kaplan and Dr. Astrid Dunsis (Victorian Foundation for Survivors of Torture Inc. www.survivorsvic.org.au, tel. 9388 0022).

The Medical Director template version of the refugee health assessment, a double-sided "cheatsheet and flowchart" and this training guidebook have been prepared by Noel Stewart, North East Valley Division of General Practice. All are available for download at: http://www.nevdgp.org.au/?content=14

This book can be used as part of a formal leader-led training session, or used as a self-training book.

Please note:
The instructions may vary as the screen shots, generally, are from MD3. Where there is a wide variance in the instructions or different menus this will be documented in the notes.

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Part 1 – Getting Started

Aims of this book

As part of good clinical record keeping this training workbook is provided to assist you to record your clinical information accurately, in a particular order and to use the correct tools to record that data. This is particularly important for the patient clinical information to "populate" the Refugee Health Assessment template.

The template should only be opened at the very end of the process. Patient clinical data like BP, height, weight, family and social history must not be entered directly into the template, otherwise it gets "buried" in that template, making it almost impossible for other practice clinicians to easily find the information at a later time.

Order of events (these can vary greatly depending on number of consultations)

- staff enter the demographic data into Practice Management software
- doctor or nurse enter clinical data in the appropriate part of Medical Director
- doctor orders relevant investigations
- Refugee Health Assessment template is opened and completed, being "populated" from the way information has been entered in the previous 3 steps
- Item number 701, 103, 705,or 707 should be claimed after the test results have been received and the assessment discussed with the patient
- Tests followed up

Because of the complexity of completing the refugee health assessment it will take possibly more than 1-2 visits. You may claim separate item numbers for the initial visits if an acute issue has been identified as a separate standard 23 or 36

There are several Medicare item numbers useful for billing refugee clients:

Item Description	Item No.	Item Description	Item No.
Pap smears (PIP)			
Health Card Holder	10900		
GP Management Plan	721	GPMP Review	732
Team Care Arrangement	723	TCA Review	732
Contributing to multidisciplinary care plan	729	45 – 49 Health Check	701, 703,705 or 707
GP Mental Health Care Plan	2702 2710	GP Mental Health Care Plan Review	2712
GP Mental Health Care Consultation	2713	Home Medicines Review (DMMR)	900

Allied health item numbers:

Practice Nurse Immunisation	10993	Practice Nurse Wound Management	10996

Then, when you open the template and make the necessary recommendations and referrals you can claim item 714 or 716. These items are subject to constant revision. See MBS online: www.health.gov.au/internet/wcms/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1.

Please consider that refugee clients have limited financial supports – bulk billing these clients is strongly recommended.

Part 2 – Downloading and installing the Refugee Health Assessment template into Medical Director

Downloading templates from the NEV website

It is imperative that you follow the instructions TO THE LETTER!! DO NOT open the templates in Word – you will lose the template fields.

Downloading the Refugee Health Assessment template

1. Go to the North East Valley Division of General Practice' website at: http://www.nevdgp.org.au

2. Under **Information Managemen**t click on the **IM Resources** link.

3. You will see the **Refugee Health Assessment** under the **5. Health Assessments** heading. CAREFULLY READ THE DOWNLOAD INSTRUCTIONS!!! Unless you follow these instructions the templates WILL NOT work properly.

4. Right click on the **Refugee Health Assessment** and select **Save target as…**

5. Select a location on your hard drive (one that you will be able to find later). The most convenient location is the "desktop" of your local computer.

6. Save the template with the appropriate name: **Refugee Health Assessment**

Importing templates into Medical Director

1. Open Medical Director and then open LetterWriter.

2. From the **File** menu **Modify Template** and double click on **Blank Template**.

3. From the **File** menu select **Import**.

4. Navigate your way to the location where you saved the downloaded file (most likely the desktop). Double click on it to open.

   This will place the *Refugee Health Assessment* text into the Blank Template. Click on any of the <<field:fields>> to check that that they have imported correctly as fields. The field should turn grey, like this: <<Field:Field Name>>

5. From the **File** menu select **Save as template…**

6. Type in an appropriate description, such as: **Refugee Health Assessment**. Click on **Save**.

7. Click once on one of the fields <<xxxxxx:yyyy>> and if it turns to a grey background this indicates the fields have successfully transferred.

Part 3 – Entering Patient Demographic Information

Patient demographic data

Staff can enter the demographic details using the practice management software. This will vary from practice to practice, depending which program is used.

The screen shot opposite shows the demographic information that can be used to populate the template.

Other information you may wish to collect can be recorded in the **Family/Social History** and **Warnings** (see below).

Patient details

Pt. Details | Notes

Title:
First Name:
Known as:
Surname:
Date of Birth: / /
Sex:
Head of Family
Set
Aboriginal
Torres Strait Islander
Address:
City/Suburb:
Postcode:
Home
Work
Mobile
Phone:
E-mail:
Medicare No: /
Pension No:
DVA No:
Safety Net No:
Record No:
Pension Status
None
Pension/HCC
Full DVA
Limited DVA
Auto-capitalise names
Save
Cancel

Part 4 – Medical History

The following information should be checked or entered before the health assessment is opened.

Note: The information recorded under the following headings appears in a different order in the template. It makes sense, however, to record them in the order below because of the way the different sections are laid out in Medical Director.

Patient details

It is worth clicking on the **Pt Details** tab and check the demographic details with the patient. Any inaccuracies may have to be updated in the practice management software, not Medical Director.

1. Open the patient record.
   - MD2 from the **Edit** menu > **Details** (or <F10>)
   - MD3 **Patient menu > Details…** (or Control +D)

   Check the patient details if necessary.

2. There is no need to click on **Save** yet, but proceed to the next tab (Family and Social History).

Family and social history

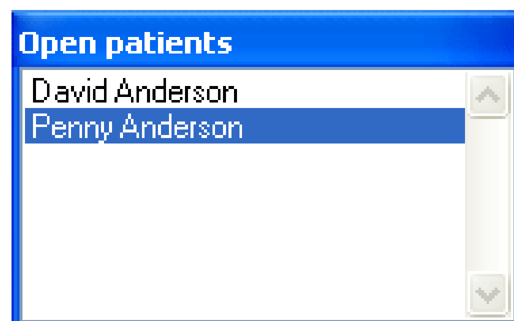
What to record:
Marital Status and Occupation
Family: *Relevant family history including country of birth and ethnicity*
Social: *Date of arrival and from which country. Countries/places of transit. Current household composition, significant family members overseas. Consider asking about previous occupation, educational level and/or religion.*

1. Click on the **Family/Social Hx** tab.

2. Fill out the details.

3. There is no need to click on **Save** yet, but proceed to the next tab (Allergies and Warnings).

Hints:
Where you have a number of family members you can copy and paste Family and Social Histories between those family members.



You can have all the family records open at the same time:

- MD2 - File > Open Another patient
- MD3 – patient > Open Another…

You can simply switch between the patient records.

Allergies and warnings

The allergy status should be recorded for all patients to comply with the new accreditation standards.

Allergies

1. Double click on the red writing next to **Allergies**:

2. Ask the patient what allergies they have and what, the reaction is.

3. Click on the **Add allergies** button. Add the appropriate details.
   Note: 1: You should click on the **No Known Allergies** checkbox for those patients that have no known allergies. This will mean that in summaries and referrals "No known allergies" will display rather than "None Recorded".

   Note 2: In MD3 you can only free type in an allergy (such as peanuts) by clicking on the **Other** radio button.

Patient details

Pt. Details | Allergies/Warnings | Family/Social Hx | Notes | Smoking | Alcohol

Allergies

Item	Reaction
PENICILLINS	

No Known Allergies | Add allergy | Delete allergy

Warnings

Needs interpreter in Acheron.

Elite sportsperson

Update address for all family members | Save | Cancel

Auto-capitalise names

Warnings

Include whether interpreter needed and in what language.

Smoking and alcohol status

This information is also added to your Progress Notes.

1. Click on the **Smoking** tab.

2. You have the choice of completing a smoking assessment or simply recording the number of cigarettes smoked per day.

3. Click on the **Alcohol** tab. Like the smoking tab, you can complete a comprehensive assessment, or simply record the number of standard drinks per day.

Medical history

CURRENT MEDICAL PROBLEMS / PATIENT CONCERNS:

Systems review

Consider fevers, confusion, severe pain, headaches, abdominal pain, bowel disturbance, breathing difficulties, muscles/joint pains, cough, haemoptysis, night sweats, injuries, weight loss, poor appetite, dark urine, growth in children.

PROGRESS NOTES:

Depending on the level of use, you can record some or all of the above information (plus the History and Examination) in your Progress Notes. The Refugee Health Assessment template allows you to populate the templates with a selection of Progress Notes – this

can be handy, especially when the information collection takes place over two or more visits and where more than one clinician is involved (such as GP and Nurse).

1. Click on the **Progress Notes** tab.

2. Click on the **History** button and fill in the appropriate detail.

3, Click on **Examination** and fill in the appropriate details.

Past medical history

Consider malaria, TB and previous Rx, operations, injuries, hospitalisations, transfusions, circumcision, malnutrition.

Adding a retrospective history item
Medical Director keeps a Past Medical History list for each patient. It is here that you can put in your patient's retrospective history items. This is intended for use as a summary of the patient's history for addition to letters and for viewing the major events in the patient's medical history.

Exercise

1. Click on the **Past history** tab in the patient's clinical screen.

2. Click on the red + toolbar button so that the **New History Item** window is displayed.

3. For the year type in 2000.

4. Delete the date.

5. For **Condition** type in TUBER and then double click on **Tuberculosis** in the drop down list. Make sure the **Summary** box is checked.

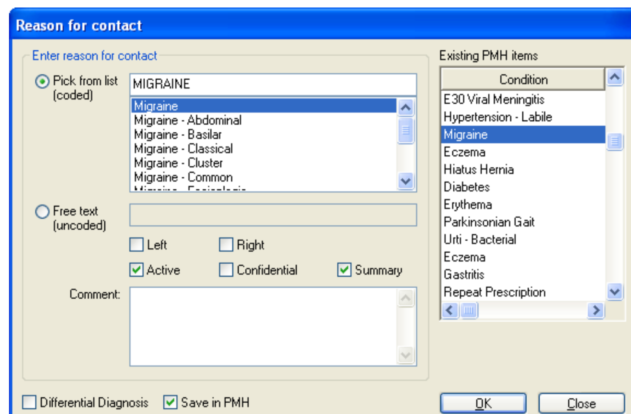
6. For **Comment:** you can type in: Had Isoniazid treatment in Egypt for 9 months. (Hence it is marked as inactive)

7. Click **OK** to close the **New History Item** window. You will notice that the history item you have created is added to the history list in chronological order.

Adding a current history item from the progress notes

1. Click on the **Progress** tab in the patient's clinical screen.

2. Click on the **Reason** button – the **Reason for contact** window will appear, which is similar to the **Reason for Prescription** window when you are prescribing medications (except here you can add a differential diagnosis).



3. Enter a reason for the contact and make sure that the **Save in PMH** and **Summary** boxes are checked, if appropriate.

4. Click on the **Past history** tab and you will see that the diagnosis has been added to the patient's history (if the **Save in PMH** box was checked).

5. From the **Summaries** menu select **Full summary** – only those items that have had the **Summary** checkbox ticked will appear.

Please note: Current history items can also be added whilst prescribing using ***Reason for Prescription.***

Current medication list

It is well worthwhile clicking on the **Current Rx** tab and checking that this reflects the current medication list of the patient. Check also that there are no duplicates or medications the patient is no longer taking. Add medications where appropriate. If you are a nurse and feel there may be an error, consult with the doctor or doctors of the practice. A nurse cannot change the medication list.

Checking immunisations

(If no clear documentation or history of immunisation, restart vaccination schedule according to Australian Immunisation Handbook http://www9.health.gov.au/immhandbook*. May check vaccine antibodies if unsure of vaccine efficacy. See Part 2 Vaccination for Special Risk Groups – Section 2.3.)*

1. Click on the **Imm**. (Immunisation) tab.

2. Check that the immunisations are up-to-date.

3. Add retrospective immunisations where appropriate and record any immunisations that you perform.

Updating obstetric/gynaecology history (if applicable)

If possible take this part of history without other family members present.
Pregnancies: *gravidity, parity, childhood separations or deaths, ask if could be currently pregnant*

1. Click on the **Obstetric** tab.

2. Click on the **Past pregnancy** button and update the obstetric history.

Please Note: Other sections of the obstetric/gynaecology need to be filled in within the template

Part 5 – Physical Examination

Recommend examine for jaundice, pallor, dentition, ENT, eyes, hair, skin – (e.g. hypopigmentation), injuries, lymphadenopathy, thyroid, cardiovascular, respiratory, abdominal examination check for hepato-splenomegaly, urinalysis.

For children also consider signs of rickets (bony deformity to legs, splayed wrists, delayed dentition), for boys check testicular descent and hernias.

You must try to avoid directly typing measurements (such as BP, Ht and Wt) into the progress notes or into a template (such as the refugee health assessment) as these measurements become buried in that specific set of progress notes or template. Anyone else looking at that patient's record would find it difficult to find previous measurement PLUS the measurements cannot be graphed or compared with previous measurements.

Note: The BP, HT/Wt tools and recording temperature can all be accessed from the **Examination** module of the progress notes. There are also BP and Ht/Wt tools on the toolbar – you use these, not only to record but also see graphs of the patient's measurements.

Blood pressure

BP

BP

1. From the **Select patient from list.**

2. Click on **Progress Notes**, select the **Examination** button and then **General** tab. (You can also click on the **BP** button from the toolbar at the top of the screen).

3. Type in the systolic and diastolic measurements in a sitting position.

Height and weight

1. Type in the patient's height and weight measurements (waist measurement optional). The BMI will be automatically calculated. Click on **Save**.

Temperature

1. Fill in the patient's temperature and record from where taken.

2. Click on **Save** and you will see that the measurements have been added to the progress notes.

3. Check the BP and Ht/Wt tools if you want to graph the measurements.

Refugee investigations checklist

This table may be useful for recording a summary of the investigations. You can autopopulate selected results once you are in the health assessment template.

These tests are indicated for most refugees/immigrants from a resource-poor setting. This list has been adapted from the Australian Society for Infectious Diseases (ASID) Recommendations. Informed consent is required. Tick tests ordered and circle results.

TEST	RESULT		DATE	DETAILS
MALARIA				
☐ RAPID TEST (e.g. ICT) and/or	☐ Normal	☐ Abnormal	______	Results need to be checked the same day and the patient referred to the local ED if positive
☐ THICK & THIN FILMS (ASID recommends test all new arrivals. Malaria endemic areas include Africa, Pakistan, Burma)	☐ Normal	☐ Abnormal	______	
TUBERCULOSIS				
☐ MANTOUX TEST or	Diameter _____ mm		______	
☐ INTERFERON GAMMA ASSAY eg. QuantiFERON gold (Medicare rebate if immuno-compromised)	☐ Negative	☐ Positive	______	If +ve, needs CXR and consider referral to ID physician
HEPATITIS B and C				
☐ sAg (surface antigen)	☐ Negative	☐ Positive	______	If sAg +ve or cAb +ve/sAg –ve or HepC Ab +ve needs further assessment
☐ sAb (surface antibody)	☐ Negative	☐ Positive	______	
☐ cAb (core antibody)	☐ Negative	☐ Positive	______	
☐ Hepatitis C antibody*	☐ Negative	☐ Positive	______	
PARASITE SEROLOGY				
☐ SCHISTOSOMA AB	☐ Negative	☐ Positive	______	If +ve check end urine and stool
☐ STRONGYLOIDES AB	☐ Negative	☐ Positive	______	If +ve check stool For treatment see Ab. guidelines
RUBELLA (If female < 45)				
☐ RUBELLA IgG antibody	☐ Negative	☐ Positive	______	If –ve, give MMR vaccine
NUTRITIONAL/VITAMIN DEFICIENCY				
☐ FBE	☐ Normal	☐ Abnormal	______	Re FBE: If eosinophilia, consider treating with albendazole unless pregnant, or already received with pre-departure treatment, and review parasite serology.
☐ LFTs	☐ Normal	☐ Abnormal	______	
If child or female: ☐ FERRITIN	☐ Normal	☐ Abnormal	______	
If dark skin/covered/ XS time indoors:				
☐ VITAMIN D LEVEL	☐ Normal	☐ Abnormal	______	Treat iron and Vit.D deficiencies
If child: ☐ VITAMIN A LEVEL	☐ Normal	☐ Abnormal	______	Consider treating Vit.A deficient risk groups without testing
SEXUALLY TRANSMITTED INFECTIONS				Pre-test and post-test counselling required for all and parental consent needed for children if concern over possible exposure.
If Past Hx of sexual activity:				
☐ CHLAMYDIA First pass urine or swab for PCR	☐ Negative	☐ Positive	______	
☐ GONORRHOEA First pass urine or swab for PCR	☐ Negative	☐ Positive	______	
☐ SYPHILIS SEROLOGY	☐ Negative	☐ Positive	______	For treatment see Ab. guidelines
☐ RPR/TPPA	☐ Negative	☐ Positive	______	
☐ HIV	☐ Negative	☐ Positive	______	If +ve HIV referral to ID physician
(Note: ASID recommends HIV testing for all refugees)				
GASTROINTESTINAL				
☐ Stool COP MC+S if symptomatic, persistent eosinophillia or risk group (for example, child)	☐ Negative	☐ Positive	______	For treatment see Ab. guidelines
☐ Urease breath test for H Pylori if epigastric symptoms	☐ Negative	☐ Positive	______	
CHRONIC DISEASE/CANCER SCREENING according to age/gender (For example, fasting chol/TGs/glucose, PAP smear, mammography)			______	
GENITO-URINARY MSU (if the urinalysis is abnormal)			______	

*At risk groups for Hep C include transit through Egypt/other risk areas, or Hx of circumcision, operation

Part 6 – Filling out the Refugee Health Assessment (Items 701, 703, 705 or 707)

Opening and completing the health assessment

1. Open LetterWriter by clicking once on the LetterWriter button and from the **File** menu select **New** and then select the **Refugee Health Assessment** from the list and click on **Open**.

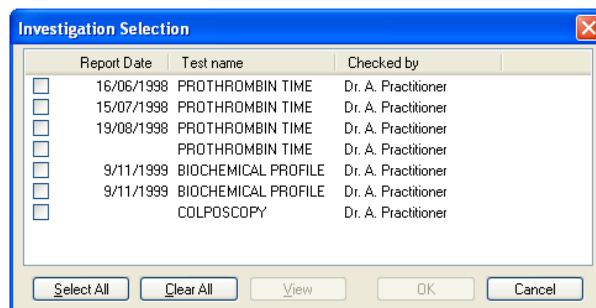
2. Select relevant **Progress Notes Selection**.

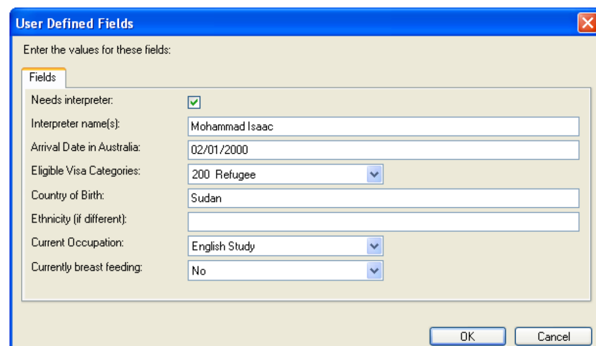
3. Select relevant **Investigations**

4. You will be prompted to fill in the **User Defined Fields**.

5. You will then see that the template has been auto populated with medications, histories, family/social history, BP Ht/Wt, allergies etc.

6. Complete the rest of the assessment.





Deleting irrelevant sections

Any sections that are not relevant, (such as paediatric, sexual health, obst/gynae history) should be deleted – highlight unwanted text and press the delete button. See the Editing tables section below for deleting tables or parts of tables.

Adding relevant sections

The following sections are filled in and explained as part of the template:

- Pre-departure medical screening
- Nutritional assessment
- Mental health history
- Paediatric screening
- Problem list and plan
- TB contacts
- Settlement stresses and support
- Female/Male sexual health
- Investigation results
- List of referrals

Hints for filling out the assessment

Adding a provider's address details to referrals

You are able to fill out the clinicians details when referring by linking to the Address Book.

1. From the **View** menu of LetterWriter select **Data Toolbar** (or Control + D).

2. Insert the cursor where you want the provider's details to go.

3. Click on the + sign next to **Addressee** and then select **Full details**. This takes you to your Address Book and you are able to select your provider.

Adding a check box

Some Medical Director templates have a check box so the ☐ becomes ☒. The trick is to highlight the checkbox (just the check box, not the space that follows) and type an x. If just the x appears it means you have highlighted more than the checkbox. You must immediately undo to return it to "normal". Remember Medical Director only allows you ONE undo!

Editing Tables by removing or adding rows

Measurements

The patient's height, weight and blood pressure measurements are displayed in a table – this table includes all the measurements and their dates that you have recorded for the particular patient, as shown below.

Date	Height	Weight	Systolic BP (Sitting)	Diastolic BP (Sitting)
24/6/1999			120	70
5/2/2000	175	85	150	80
23/10/2002	175	80	150	
5/11/2002			184	96
28/11/2002	175			
14/2/2003	175	70	135	85

You may wish to only include the last measurement, in which case you need to delete the unnecessary measurements. Highlighting and deleting the "offending" text removes the text but leaves the table intact. A better approach is to delete rows of the table.

How to remove rows

1. Highlight the text you wish to remove, as shown below.

Date	Height	Weight	Systolic BP (Sitting)	Diastolic BP (Sitting)
24/6/1999			120	70
5/2/2000	175	85	150	80
23/10/2002	175	80	150	
5/11/2002			184	96
28/11/2002	175			
14/2/2003	175	70	135	85

2. From the **Table** menu select **Delete** and then **Rows** – your measurements table will now look like this:

Date	Height	Weight	Systolic BP (Sitting)	Diastolic BP (Sitting)
14/2/2003	175	70	135	85

Note: Rows can also be removed in the Past History and Medication lists in the same way.

Removing unused rows

In many Medical Director templates you have unused rows in tables as in the example below where you wish to remove the bottom 2 rows.

NAMES OF AGENCIES INVOLVED	**CONTACT DETAILS**	
	Office	
	Mobile	
	Email	
	Office	
	Mobile	
	Email	

Removing rows of a table

1. Insert the cursor in the row you wish to delete.
2. From the **Table** menu select **Delete** and then **Rows**.
3. Remove the last row using the same method.

Adding a row to a table

1. Insert the cursor in the row above where you wish to add a row.
2. From the **Table** menu select **Insert** and then **Rows Below**.

Note: Columns can also be added to a table using the same method.

LetterWriter - Inserting and removing Page Breaks

As you type in information or "populate" the HMR from the Medical Director database you will find that you may have the following layout problems:

- a table broken in two (half spilling onto the next page)
- a single (or a few) lines at the top or bottom of the page (widows and orphans)
- a blank page
- an almost blank page

In these and other cases you need to know how to insert and delete page breaks. A very bad method of getting text to appear at the top of a page is to press the Enter key several times until the text appears on the next page. This is a very bad habit – DON'T DO IT. Use page breaks instead.

Scenario 1 – a table is spread over 2 pages

What you want instead is the complete table to appear on the following page.

1. Insert the cursor in the line above the table (NOT IN THE FIRST LINE OF THE TABLE)
2. From the **Insert** menu select **Page Break** (or press Control + Enter). The table will now begin on the next page.

Scenario 2 – you only have a few lines on a page, the rest of the text is on the next page

What has happened here is that there is a **Page Break** inserted in the text. You can't see it but you can delete it.

1. Insert the cursor at the end of the text that is sitting on the top of the page.
2. Press the **Delete** key on the keyboard. You may have to press the **Delete** key a few times until the text of the following page is retrieved.