MEDICAL REPORT
MEDICAL HISTORY QUESTIONS

UCI number:	IME number:	UMI number (if applicable)

Family name	Given name(s)	Date of birth (YYYY-MM-DD)

IF YOUR ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE ADDITIONAL INFORMATION INCLUDING: DIAGNOSIS, DATE, AND TREATMENT (INCLUDING MEDICATIONS AND/OR MAJOR SURGERIES)

MEDICAL HISTORY QUESTIONS	RESPONSE	ADDITIONAL INFORMATION FOR "YES" RESPONSE ONLY
1. Tuberculosis (TB), treatment for tuberculosis	☐ No ☐ Yes	
2. Close household or work contact with Tuberculosis **(CXR will be required for all clients regardless of age)**	☐ No ☐ Yes	
3. Prolonged medical treatment and/or repeated hospital admissions for any reason, including a major operation or psychiatric illness	☐ No ☐ Yes	
4. Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia).	☐ No ☐ Yes	
5. An abnormal or reactive HIV blood test	☐ No ☐ Yes	
6. An abnormal hepatitis B or hepatitis C blood test	☐ No ☐ Yes	
7. Cancer or malignancy in the last 5 years	☐ No ☐ Yes	
8. Diabetes	☐ No ☐ Yes	
9. Heart condition including coronary disease, hypertension, valve or congenital disease	☐ No ☐ Yes	
10. Blood condition (including thalassemia)	☐ No ☐ Yes	
11. Kidney or bladder disease	☐ No ☐ Yes	
12. 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).	☐ No ☐ Yes	
13. An addiction to drugs or alcohol	☐ No ☐ Yes	
14. Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the-counter medication and natural supplements)	☐ No ☐ Yes	
15. **For female clients:** a) Are you pregnant?	☐ No ☐ Yes	
b) If yes, what is the expected date of delivery?	Date (YYYY-MM-DD)	
c) Do you wish to proceed with the required x-ray examination?	☐ No ☐ Yes	

MEDICAL REPORT
PHYSICAL EXAMINATION

UCI number:	IME number:	UMI number if applicable

Family name	Given name(s)	Date of birth (YYYY-MM-DD)

FOR ABNORMAL FINDINGS, PLEASE PROVIDE: HISTORY, DIAGNOSIS, TREATMENT DETAILS (INCLUDING DATES AND MEDICATIONS), LAB RESULTS, SPECIALIST REPORTS (AS REQUIRED), CURRENT STATUS AND PROGNOSIS.

PHYSICAL EXAMINATION	RESPONSE	COMMENTS ON ABNORMALITIES
Date of examination	Date (YYYY-MM-DD)	
16. Was a chaperone offered?	☐ No ☐ Yes	
17. Was a chaperone present?	☐ No ☐ Yes	
18. a) **Height** _____ cm Age ≤ 2 Yrs: _____ Percentile	☐ Normal ☐ Abnormal	For results in 3rd percentile provide Paediatric report.
18. b) **Weight** _____ kg Age ≤ 2 Yrs: _____ Percentile	☐ Normal ☐ Abnormal	
18. c) **BMI** _____ BMI (For clients ≥ 18 years)	The BMI will automatically be calculated by the CIC electronic system. The panel physician must enter the height in cm and the weight in kg above.	
19. **Head Circumference** (children ≤ 2 years old) _____ cm _____ Percentile	☐ Normal ☐ Abnormal	
20. **Ear / Nose / Throat / Mouth**	☐ Normal ☐ Abnormal	
21. **Hearing**	☐ Normal ☐ Abnormal	
22. **Eyes** (include Fundoscopy)	☐ Normal ☐ Abnormal	
23. **Best Distance Visual Acuity** (with or without correction) (Possible adult values: 6/6 to 6/60)	Adult / Children R _____ ☐ Normal L _____ ☐ Abnormal	
24. **Blood Pressure** (required for all clients 15 years and older) Hypertension: ≥ 140 / ≥ 90 Systolic: _____ Diastolic: _____	☐ Normal ☐ Abnormal	

UCI number:	IME number:	UMI number (if applicable):

Family name	Given name(s)	Date of birth (YYYY-MM-DD)

25. **Cardiovascular System**	☐ Normal ☐ Abnormal	
26. **Respiratory System**	☐ Normal ☐ Abnormal	
27. **Nervous System** Sequelae of stroke or cerebral palsy or other neurological disabilities.	☐ Normal ☐ Abnormal	
28. **Mental and Cognitive State**	☐ Normal ☐ Abnormal	
29. **Intellectual Ability**	☐ Normal ☐ Abnormal	
30. **Developmental Milestones** (for all clients less than 5 years of age)	☐ Normal ☐ Abnormal	
31. **Gastrointestinal System**	☐ Normal ☐ Abnormal	
32. **Musculoskeletal**	☐ Normal ☐ Abnormal	
33. **Skin and Lymph Nodes**	☐ Normal ☐ Abnormal	
34. **Evidence of substance abuse (e.g., venous puncture marks)** (provide any history of violent behaviour related to substance abuse)	☐ No ☐ Yes	
35. **Breast examination** (where there are concerns regarding changes in breast(s))	☐ Normal ☐ Abnormal	
36. **Endocrine System** (such as evidence of complications from diabetes)	☐ Normal ☐ Abnormal	
37. Are there any physical or mental conditions which may prevent this person from attending mainstream school, gaining full employment or living independently now or in the future?	☐ No ☐ Yes	

MEDICAL REPORT
LABORATORY REQUISITION AND REPORT

UCI number:	
IME number	
UMI number (if applicable):	

PHOTOGRAPH required for all clients. Must be taken within six months of the medical examination.

Family name	Given name(s)	
Date of birth (YYYY-MM-DD)	Country of birth	Gender

I have confirmed the BIODATA / Identity of the client ▶ ☐ No ☐ Yes

I have concerns about the BIODATA / Identity of the client ▶ ☐ No ☐ Yes ▶ If YES, please provide details:

- Persons collecting blood or receiving specimen should sign or provide name in the corresponding signature/name box to confirm the sample was collected from the individual identified above.
- Return this form and corresponding lab results/reports to the Panel Physician.

Panel Physician name	Panel Physician address	Fax number

PLEASE PERFORM THE LABORATORY TESTS INDICATED BELOW

REQUIRED ☑	TEST DESCRIPTION	RESULT (PLEASE CHECK)	SIGNATURE OR NAME OF THE PERSON COLLECTING THE SAMPLE	DATE (YYYY-MM-DD)
☐	Urinalysis Dipstick	Normal ☐ Abnormal ☐ ☐ Blood ☐ Protein ☐ Glucose		
☐	Urinalysis Microscopy	Normal ☐ Abnormal ☐ (Attach actual laboratory report)		
☐	Syphilis Serology	Negative ☐ Positive ☐ (Attach actual laboratory report) Indeterminate ☐ (Attach actual laboratory report)		
☐	HIV Serology	Negative ☐ (Attach actual laboratory report) Positive ☐ (Attach actual laboratory report) Indeterminate ☐ (Attach actual laboratory report)		

PLEASE ATTACH AN ACTUAL LABORATORY REPORT FOR THE FOLLOWING COMPLETED TESTS, REGARDLESS OF THE RESULT

☐	Serum Creatinine	Normal ☐ Abnormal ☐		
☐	HBsAg	Normal ☐ Abnormal ☐		
☐	Hep C Ab	Normal ☐ Abnormal ☐		
☐	ALT	Normal ☐ Abnormal ☐		
☐				
☐				

MEDICAL REPORT
CHEST X-RAY REQUISION AND REPORT

UCI number:		
IME number:		
UMI number:		
Family name	Given name(s)	
Date of birth (YYYY-MM-DD)	Country of birth	Gender

PHOTOGRAPH required for all clients. Must be taken within six months of the medical examination.

Routine PA (posteroanterior) chest X-ray is required. ▶ **Date of exam: (YYYY-MM-DD)**

TECHNICIAN/RADIOGRAPHER DECLARATION

I have confirmed the BIODATA / Identity of the client ▶ ☐ No ☐ Yes

I have concerns about the BIODATA / Identity of the client ▶ ☐ No ☐ Yes ▶ If YES, please provide details:

Technician/Radiographer signature

Date (YYYY-MM-DD)

IMMIGRATION MEDICAL RADIOLOGY GRADING

Please consider the information you have provided about this client. You must consider if there is any evidence of TB or other significant findings. Significant means that a finding has a current or potential health impact.

☐ **A:** No evidence of active TB or changes suggestive of other significant diseases identified.

☐ **B:** Evidence of active TB or changes suggestive of other significant diseases identified.

Comments:

PANEL RADIOLOGIST DECLARATION

I confirm that this immigration radiology examination and report is a true and accurate record of my findings.

Panel Radiologist name	Panel Radiologist no.

Panel Radiologist signature

Date (YYYY-MM-DD)

UCI number:	IME number:	UMI number (if applicable):

Family name	Given name(s)	Date of birth (YYYY-MM-DD)

CHEST X-RAY REPORT

QUESTIONS/FINDINGS	RESPONSE	DESCRIPTION OF ABNORMAL FINDINGS
Is the client pregnant?	☐ No ☐ Yes	
What is the expected date of delivery?	Date (YYYY-MM-DD)	
Has the pregnant woman advised that she wishes to proceed with the required x-ray examination?	☐ No ☐ Yes	
Skeleton and soft tissue	☐ Normal ☐ Abnormal	
Cardiac shadow	☐ Normal ☐ Abnormal	
Hilar and lymphatic glands	☐ Normal ☐ Abnormal	
Hemidiaphragms and costophrenic angles	☐ Normal ☐ Abnormal	
Lung fields	☐ Normal ☐ Abnormal	
Evidence of tuberculosis?	☐ No ☐ Yes	
This chest x-ray is suspicious of Active TB	☐ No ☐ Yes	

RECORD OF SPECIAL FINDINGS NOTED ON THE CLIENT'S CHEST X-RAY

FINDINGS	GRADE
Single fibrous streak/band/scar	1.1 ☐
Bony islets	1.2 ☐
Apical pleural capping with a smooth inferior border (< 1 cm thick at all points)	2.1 ☐
Unilateral or bilateral costophrenic angle blunting (below the horizontal)	2.2 ☐
Calcified nodule(s) in the hilum / mediastinum with no pulmonary granulomas	2.3 ☐
Solitary granuloma (< 1 cm and of any lobe) with an unremarkable hilum	3.1 ☐
Solitary granuloma (< 1 cm and of any lobe) with calcified / enlarged hilar lymph nodes	3.2 ☐
Single/multiple calcified pulmonary nodules/micro-nodules with distinct borders	3.3 ☐
Calcified pleural lesions	3.4 ☐
Costophrenic angle blunting (either side above the horizontal)	3.5 ☐
Notable apical pleural capping (rough or ragged inferior border and / or ≥ 1 cm thick at any point)	4.0 ☐
Apical fibronodular / fibrocalcific lesions or apical microcalcifications	4.1 ☐
Multiple / single pulmonary nodules / micro-nodules (noncalcified or poorly defined)	4.2 ☐
Isolated hilar or mediastinal mass / lymphadenopathy (noncalcified)	4.3 ☐
Single / multiple pulmonary nodules / masses ≥ 1 cm	4.4 ☐
Non-calcified pleural fibrosis and / or effusion	4.5 ☐
Interstitial fibrosis / parenchymal lung disease / acute pulmonary disease	4.6 ☐
ANY cavitating lesion OR "Fluffy" or "Soft" lesions felt likely to represent active TB	4.7 ☐
NONE of the above are present	0 ☐