Version	Date	Changes
Version 1.0	*04/04/22*	*Originally published Rapid Health Risk Assessment V1.0*
Version 2.0	*05/05/22*	*Name and content change* *Inclusion of triage guidance and notes*
Version 2.1	*13/05/22*	*Inclusion of disability questions*
Version 2.2	*23/05/22*	*Changes to Acknowledgment page*
Version 2.3	*24/05/25*	*Hyperlink to HSE Privacy Notice updated*

Acknowledgement

Thank you for completing the Individual Health Assessment Questionnaire.

Your participation is voluntary.

The HSE will treat all personal data you provide as part of this questionnaire confidentially and store it securely.

This record will be used and retained by the HSE, for the purposes of organising health services for you and as part of a broader health needs assessment for the wider population of displaced people from Ukraine.

By completing the healthcare questionnaire and providing your contact details you acknowledge the following:

- *The HSE (Irish health service) may send you an email containing your healthcare questionnaire responses*
- *The HSE may share your healthcare data within the HSE for provision of healthcare services*
- *The HSE may share your healthcare data with other public/government bodies*
- *The HSE may contact you regarding your future health needs*

To learn more about how the HSE process your personal information please see the HSE Privacy Notice.

☐ I fully understand that all information shared is confidential. However, under the infectious disease and child welfare and protection legislations, infectious disease and child protection concerns will be reported to the relevant authorities.

☐ I understand that I do not have to take part in this assessment and that opting out won't affect my future medical care with the HSE. However, under the infectious disease and child welfare and protection legislations, I understand that infectious disease and child protection concerns will be reported to the relevant authorities.

Your signature:		Date:	_____/____/_____

Name: _____ DOB: ____/____/_____

Individual Health Assessment Questionnaire

Part 1: Demographic information					
First Name		**Surname**			
Date of Birth	____/____/_____ (DD/MM/YYYY)		**Gender**	Male ☐ Female ☐	
PPSN					
DOJ Temporary Permission ID					
National ID number (Passport/Ukrainian ID)					
Current Irish Address			**Eircode**		
Date of arrival in Ireland	____/____/_____ (DD/MM/YYYY)				
Irish Phone Number	+ _____ _____				
Additional Phone Number (with country Prefix)	+ _____ _____				
Do you need a translator?	Yes ☐ No ☐	**If yes, what languages do you speak?**	Ukrainian ☐ Russian ☐ Other: _____		
Name of person completing the form if on behalf of someone else		**Relationship**	Parent ☐ Guardian ☐ Other ☐		
If under 18 years old, is the person an unaccompanied minor?			Yes ☐ No ☐		
Are you pregnant or have you given birth in last 3 months?	Yes ☐ **If Yes refer to clinical triage** No ☐				

Part 2: Acute medical issues		
	Yes	**No**
Are you currently unwell? (e.g. fever, respiratory, diarrhoeal, rash, wound)	☐	☐
Dental emergency? (e.g. mouth pain, dental abscess, broken tooth)	☐	☐

Part 3: Medications			
Any known allergies?	Yes ☐ No ☐	**if yes, what?**	
Are you currently on medications?			Yes ☐ No ☐
If yes, do you need a new supply within the next 4 weeks?			Yes ☐ **If Yes refer to clinical triage** No ☐

Name: _____ DOB: ____/____/_____

Part 4: Chronic medical issues	Yes	No
Do you regularly attend a family doctor, community services, or hospital out-patient service in Ukraine?	☐	☐
Are any of the following conditions present or diagnosed?	**Yes**	**No**
Heart disease	☐	☐
History of stroke	☐	☐
Diabetes Mellitus Type 1	☐	☐
Diabetes Mellitus Type 2	☐	☐
Chronic respiratory disease (e.g. COPD or asthma)	☐	☐
Chronic Kidney Disease	☐	☐
• Do you require kidney dialysis?	☐	☐
Epilepsy	☐	☐
Serious mental health issue	☐	☐
• Major depressive disorder	☐	☐
• Schizophrenia	☐	☐
HIV	☐	☐
Hepatitis B /Hepatitis C	☐	☐
Immunocompromised	☐	☐
• Cancer	☐	☐
• Organ transplant	☐	☐
Other	☐	☐
Other medical concern: provide details		
If yes to any questions above, refer to clinical triage and onward referral as required		

Part 5: Lifestyle factors	
Current smoker	Yes ☐ No ☐ If Yes refer to stopsmoking.org.ua
History of intravenous drug use	Yes ☐ No ☐ If Yes refer to clinical triage
Excessive alcohol use requiring treatment	Yes ☐ No ☐ If Yes refer to clinical triage
Would you like to be tested for HIV/ Hepatitis B/ Hepatitis C?	Yes ☐ No ☐ If Yes refer to clinical triage

Name: _____ DOB: ____/____/_____

Part 6: Disability	No - no difficulty	Yes - some difficulty	Yes - a lot of difficulty	Cannot do at all
Do you have difficulty seeing, even if wearing glasses?	☐	☐	☐	☐
Do you have difficulty hearing, even if using a hearing aid?	☐	☐	☐	☐
Do you have difficulty walking or climbing steps?	☐	☐	☐	☐
Do you have difficulty remembering or concentrating?	☐	☐	☐	☐
Do you have difficulty (with self-care such as) washing all over or dressing?	☐	☐	☐	☐
Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?	☐	☐	☐	☐
Do you think that [your child] has difficulties learning or behaving like other children of the same age?	☐	☐	☐	☐
Do you use any device or technology to help you with any of the above difficulties?				Yes ☐ No ☐
• if yes, what?				
If yes to any questions above, refer to clinical triage				

Part 7: Tuberculosis			
Have you ever been treated for TB?	Yes ☐ No ☐	If yes when?	___ months ago
Was treatment completed?	Yes ☐ No ☐ Don't know ☐		
Have you had contact with anyone with TB in the last 6 months?	Yes ☐ No ☐ Don't know ☐		
Do you have any of the following symptoms?	New Cough >3 weeks		Yes ☐ No ☐
	Sputum/phlegm		Yes ☐ No ☐
	Coughing up blood		Yes ☐ No ☐
	Unexplained weight loss		Yes ☐ No ☐
	Drenching night sweats		Yes ☐ No ☐
If yes to any questions above re TB, refer to clinical triage			

Name: _____ DOB: ____/____/_____

Part 8: COVID-19	
Have you had COVID-19 infection in the last 3 months?	**Yes** ☐ **No** ☐ **Don't know** ☐
Have you been vaccinated against COVID-19?	**Yes** ☐ **No** ☐

If you have been vaccinated:

Number of doses	**Name of vaccine** e.g. Moderna/Spikevax, Pfizer-BioNTech/Comirnaty, Janssen /Johnson & Johnson, Oxford-AstraZeneca/Vaxzevria, Serum Institute of India/Covishield, Sinovac/CoronaVac	**Date of last vaccination** *(approximately if don't know)*
Dose 1		_____/____/_____
Dose 2		_____/____/_____
Dose 3		_____/____/_____

Everyone aged 5 years and over is eligible for a COVID-19 vaccination.

Would you like a COVID-19 Vaccination?	**Yes** ☐ **If yes, provide information on COVID-19 vaccination** **No** ☐

Part 9: Vaccination history				
Have you (or your child) received all the vaccines recommended in Ukraine for your (or their) age?	☐	**Yes and have written record of vaccination**	☐	**No**
	☐	**Yes and have verbal record of vaccination**	☐	**Don't know**
All children and young adults up to the age of 23 should be referred to the GP or CHO for catch-up vaccination				

There are some vaccines that are recommended in Ireland that are not given in Ukraine. These vaccines protect against diseases like meningococcal infection and pneumonia. It's important that children and young people who are living in Ireland receive these vaccines. If you or your child have missed some vaccines in Ukraine you should also catch-up with these vaccines. You will find more information www.immunisation.ie. Talk to your Doctor or nurse about the vaccines that you or your child may need.

Your signature:		Date the form was completed:	_____/____/_____

For HSE Purposes Only:			
Review completed by (BLOCK CAPITALS):	Signature:	Role:	Date:

Name: _____ DOB: ____/____/_____

Individual Health Assessment Questionnaire Triage Notes for Healthcare Professionals

The Individual Health Assessment Questionnaire for people displaced by the war in Ukraine is designed to be self-administered or administered with the assistance of a non-healthcare professional.

Referral to clinical triage is required if indicated by the questionnaire.

Situations where it is appropriate to refer for clinical triage:

- Those who are pregnant or who have given birth in last 3 months
- Those requiring medical prescriptions within 4 weeks
- Those with acute or chronic medical conditions / disability that require medical attention to prevent rapid deterioration or could influence onward accommodation needs
- Those with risk factors for drug/alcohol withdrawal or those with major mental health condition
- Those who answer yes to any of the tuberculosis (TB) related questions
- If blood-borne virus testing is available:
    - Those who would like to be tested for blood-borne viruses (HIV/ Hepatitis B/ Hepatitis C)
- If COVID-19 vaccination is available:
    - Those who would like to be vaccinated for COVID-19

Assessment of the questionnaire and clinical triage should be provided by the relevant Community Healthcare Organisation (CHO). A mechanism for onward referral to an appropriate service should be put in place.

A local referral pathway document should be developed in each area where this questionnaire is implemented to help guide those doing clinical triage on where appropriate referrals should be made to.

The following categorisation system may be helpful when prioritising referrals to medical services/ primary care.

Category 1 Referral	**Urgent within 24 hours** GP / Out of hours GP / ED if acutely unwell or urgent script required Onward referral to hospital service if urgent service required
Category 2 Referral	**GP/ Other service review within 48 – 72 hours** Generally unwell, script required for chronic illness
Category 3 Referral	**GP/ Other service review within 4 – 6 weeks** Chronic illness review required
Category 4 Referral	**GP/ Other service review when possible*** *Note: all people should be advised to link with their assigned GP for any medical or psychological issues

*These timelines may need to adjusted

Name: _____ DOB: ____/____/_____

Triage Notes (To be completed by Healthcare Professional)

Medical Conditions:
Medications:
Clinical Notes:
Plan:

Service Requested					
General Practitioner	☐	Child Health Service	☐	Pregnancy Services	☐
Disability	☐	Mental Health Service	☐	Emergency Dental	☐
Other (give detail)					

Completed by (BLOCK CAPITALS):	Signature:	Role:	Date:

Name: _____ DOB: ____/____/_____