Citizenship and Immigration Canada | Citoyenneté et Immigration Canada

Medical Report: Section B
Functional Inquiry, Background Information and Applicant's Declaration

APPLICANT (or guardian) to answer in the presence of the examining physician.
IF YOUR ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PROVIDE DETAILS INCLUDING DATES.

HAVE YOU EVER HAD or NEEDED: Provide details below, continue on reverse if needed.

1. An operation/**HOSPITAL** treatment for any reason?	No	Yes ▶
2. Convulsions, blackouts, loss of consciousness, "fits" or **EPILEPSY**?	No	Yes ▶
3. Anxiety, depression or **NERVOUS PROBLEMS** requiring treatment?	No	Yes ▶
4. High blood pressure, any **HEART** trouble, **CHRONIC COUGH**, breathlessness or chest pain?	No	Yes ▶
5. Recurrent or **CHRONIC PAIN** in the neck, back, or any joint sufficient to interfere with work or normal day-to-day activities?	No	Yes ▶
6. Problems with **DIGESTION**, stomach pains, heartburn, blood in stool, chronic diarrhea?	No	Yes ▶
7. **TUBERCULOSIS**, a **SEXUALLY TRANSMITTED DISEASE**, or any other **COMMUNICABLE DISEASE** lasting more than 3 weeks?	No	Yes ▶
8. A history of jaundice or **HEPATITIS** involving you **OR** anyone in your immediate family?	No	Yes ▶
9. A history of **KIDNEY** or bladder disease or complaint?	No	Yes ▶
10. **DIABETES** or history of sugar in the urine?	No	Yes ▶
11. Any **OTHER ILLNESS**, injury or medical condition lasting more than 3 weeks, or a recurring condition not previously mentioned? Any recent **UNINTENTIONAL WEIGHT LOSS**?	No	Yes ▶
12. Are you taking any pills, **MEDICATION** or receiving any medical treatment?	No	Yes ▶
13. Have you ever been **ADDICTED** to alcohol or a drug, or taken drugs illegally?	No	Yes ▶
14. Have you ever had a test indicating the presence of the **HIV** virus or have you ever been told that you were suspected of having **AIDS, HIV INFECTION**, or any other immune disorder?	No	Yes ▶
15. Are you eligible for or do you receive a **PENSION** for **MEDICAL/PSYCHOLOGICAL** reasons?	No	Yes ▶
16. **AUTISM**, **MENTAL RETARDATION**, **DEVELOPMENTAL DELAY** or other physical or mental **DISABILITIES/IMPAIRMENTS** affecting your current or future ability to function independently?	No	Yes ▶
17. Any medical, psychological, alcohol related, or other **TREATMENT** in the past 5 years?	No	Yes ▶
18. Are you **PREGNANT**? If so, what is the expected date of delivery: Date Day Month Year	No	Yes
19. Previously, have you undergone a Canadian Immigration Medical examination for any reason (whether completed or not)? If so, where, when and under what name?	No	Yes ▶

List all countries (with duration of stay) where you have lived during the last five years:

Last country of permanent/long term residence prior to landing in Canada:

Occupations/activities in last 5 years:

Intended length of stay:

A. ☐ Permanent/long term B. ☐ Temporary for Months Years

Intended occupation/activity in Canada:

Declaration and Authorization of applicant (or guardian)

I hereby declare that the information I have provided is true and complete. I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information concerning my health or medical history. I also authorize the Department to release information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated. I certify that the information I have provided on this form is correct.

Applicant's Signature ▶ Date Day Month Year

Medical Report: Section C
Examining Doctor's Findings

- **Review answers provided by applicant in Section B and provide details if needed.**
- **The physical examination of organ systems should be preceded by an appropriate functional inquiry.**
- **If at any time there is ANY clinical or radiologic finding suggestive of active TB, immediately refer to an appropriate specialist and submit a specialist's report.**
- **In keeping with standard ethical practice, the applicant should be made aware of abnormalities detected, in particular conditions requiring early or urgent intervention.**

1.	**Weight / Height** (crown-heel length for infants)	_____ kg	_____ cm	**Comments on abnormalities** (continue on back of this sheet if needed)
	Head Circumference: Include an appropriate specialist report if clinically abnormal. PROVIDE **ACTUAL HEAD MEASUREMENT** FOR INFANTS ≤ 18 MONTHS OLD: _____ cm	Normal	Abnormal	
	Hearing (able to hear whispered voice at 6 metres/20 feet)	Normal	Abnormal	
	Eyes (include funduscopic exam / red reflex as appropriate) Provide a specialist report for presence or history of cataract, trauma, glaucoma, or other eye condition or disease.	Normal	Abnormal	
	Corrected Visual Acuity If necessary, use pin-hole occlusion. Provide appropriate comments for those too young to be tested. Provide a specialist ophthalmologist's report where the corrected visual acuity is abnormal (worse than 6/12 in either eye) _____ Lt.	Normal	Abnormal	
	_____ Rt.	Normal	Abnormal	
2.	**Ears, Nose, Throat, Mouth, Teeth**	Normal	Abnormal	
3.	**Endocrine System**	Normal	Abnormal	
4.	**Skin, Lymph Nodes, and Breasts** (Inspect skin for cancer, leprosy, surgical scars, and tattoos. Inspect neck, axilla, and groin for lymphadenopathy)	Normal	Abnormal	
5.	**Cardiovascular System** (e.g. evidence of heart failure or other heart / vascular abnormalities, **RHYTHM DISTURBANCES**, abnormal bruits, **TACHYCARDIA**. Describe all murmurs and clearly comment if they are felt to be functional or pathologic)	Normal	Abnormal	
	Blood Pressure (required for all applicants aged 15 and older): Systolic _____ Diastolic _____ Include a **SERUM CREATININE** and **CARDIOLOGIST'S REPORT** if repeated readings after rest are abnormal and exceed the following limits: 59 years of age or less 140 / 90; 60 years and over 160 / 90	Normal	Abnormal	
6.	**Respiratory System** (consider smoking history, chronic/recurrent lung conditions, cardiopulmonary disorders etc.) If there is a history of TB provide full details and enclose all available old chest X-ray films Provide **Respiratory Rate:** _____ **Breaths/minute** If this applicant **SMOKES**, how many pack-years? _____ **pkg.-years**	Normal	Abnormal	
7.	**Gastrointestinal System** (include a **RECTAL EXAM** if appropriate)	Normal	Abnormal	
8.	**Urogenital System** If clinically appropriate, females should be asked to provide evidence of a recent Pap smear result from their own physician or gynaecologist. Include a **PROSTATE EXAM** if appropriate.	Normal	Abnormal	
9.	**Locomotor System / Physical Build**	Normal	Abnormal	
10.	**Indication of any substance abuse?**	Normal	Abnormal	

11. **Nervous System** Sequelae of stroke or cerebral palsy, other neurologic disabilities	Normal	Abnormal	**Comments on abnormalities** (continue on back of this sheet if needed)
A) Is there any evidence of DEVELOPMENTAL DELAY? (Examples include the following: (i) infants not speaking their first word before 12 months of age, (ii) infants not speaking in two or three word sentences before 2 1/2 years of age, (iii) infants failing to walk independently before 16 months of age).	No	Yes	
B) Do you think there is ANY MENTAL RETARDATION?	No	Yes	
C) After the acquisition of appropriate English or French communication skills, is it likely that the applicant will require further SPECIAL ASSISTANCE at school AND/OR special vocational training? Is there anything to prevent this applicant from acquiring such skills?	No	Yes	
D) Is there ANY evidence of DEMENTIA (Making NO adjustments for age)? **Review all applicants for cognitive function to determine if short, medium, or long term memory deficits exist. Formal testing using Folstein's Mini-Mental Examination (or local equivalent) is recommended as appropriate.**	No	Yes	
Special Questions of Concern			
12. Is there any **Physical or Mental condition** which may affect this person's ability to earn a living, take care of themselves or adapt to a new environment, now or in their future adult life? **Document these physical or psychiatric conditions.**	No	Yes	
13. Is there any personal / family history of a condition which might reasonably lead to the requirement, now or in the future, for **Organ Transplantation** or **Dialysis?** (e.g. diabetic / lupus nephropathy, pyelonephritis, family history or personal history of polycystic kidney disease, chronic active hepatitis or hepatitis carrier state)	No	Yes	
14. Has applicant ever received treatment or follow-up for any type of **Cancer?** (if yes, provide up-to-date details & staging)	No	Yes	
15. Concerning this applicant, on average: i) How many days per week is alcohol consumed: _____ **days/week.** ii) How may drinks per week does this applicant consume: _____ **drinks/week.** iii) What is the maximum number of drinks consumed on any one occasion during the last two months: _____ **drinks.** Do you feel this applicant is at increased risk for developing **Alcohol-Related Problems**, is currently experiencing alcohol-related problems (abuse), or is alcohol dependent?	No	Yes	
16. **During the last 2 years,** has this applicant been **in close contact** with anyone who had active tuberculosis or any type of **tuberculosis** requiring treatment?	No	Yes	

Summarize abnormalities and provide your opinion as to **PROGNOSIS**. If full mobility and physical self-sufficiency is in doubt enclose an '**Activities of Daily Living Form**' or local equivalent:

DECLARATION: I declare that I have confirmed the identity and examined this applicant and that this is a true and correct record of my findings.

Examining physician's name, address and telephone number (OFFICE STAMP MAY BE USED)

Signature	Date of examination Day Month Year	Place of examination

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Medical Report: Section D
Laboratory Requisition

Surname	Forenames (First Names)	PHOTO
Applicant's Declaration: I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated.		**PHOTOGRAPH OF APPLICANT** **Required for all applicants. Must be taken within six months of the medical examination.**
Applicant's Signature	Date (Day / Month / Year)	

1. Perform the investigations requested below.

2. Person collecting blood or receiving specimen should sign in the corresponding signature box below to confirm that the sample was collected from the individual identified above.

3. Please return this form to the ordering physician.

	Urinalysis **Required: Age 5 yrs and older**	Signature

DIPSTICK FOR PROTEIN, GLUCOSE AND BLOOD. If abnormal, do a microscopic urinalysis (clean specimen).

If urinalysis is known to be unremarkable & normal, check here → ☐

	Syphilis Serology **Required: Age 15 yrs and older**	Signature

If syphilis serology is known to be nonreactive / negative, check here → ☐

	Serum Creatinine **See below for indications**	Signature

SERUM CREATININE is required for applicants with hypertension, diabetes, autoimmune disorders, a confirmed abnormal urinalysis done on a repeat clean specimen, and those with a history of urinary tract disorders or disorders potentially affecting renal function.

	24h Urine for Total Protein **Indicated if 1 + protein or more on urinalysis**	Signature
	Hepatitis B surface antigen **When indicated**	Signature
	HIV **When indicated**	Signature
	Sputum smears and cultures for TB **When indicated (collected over 3 days)**	Signature
		Signature

Medical Report: Section E
CHEST X-RAY REPORT

- **A ROUTINE chest X-ray is required for all aged 11 years and older. A chest X-ray is also required for those under 11 years of age if there is any relevant history or clinical indication** (e.g. history of TB involving any part of the body, previous contact with active TB, congenital/chronic heart/lung conditions etc.). **THE CHEST X-RAY FILM REMAINS THE PROPERTY OF THE DEPARTMENT OF CITIZENSHIP AND IMMIGRATION.**

- The chest X-ray must be on a large posteroanterior (PA) film and must bear the date of the examination, the applicant's surname and given names, and the Canadian Immigration file number (if available). **Names must be written in the ENGLISH ALPHABET**. This information is to be automatically inscribed during the photographic process or written in ink (preferably white ink). **If the examinee is pregnant, the film must be full sized, the field size must be strictly limited and there must be abdominal shielding.**

- This report is to be returned to the Physician who examined the applicant.

1. Applicant Details

Surname	Forenames (First Names)	PHOTO
Applicant's Declaration: To be signed by the applicant (or responsible guardian) in the presence of the radiographer/technologist.		**PHOTOGRAPH OF APPLICANT**
I hereby declare that the information I have provided is true and complete. I authorize any physician, laboratory, clinic or hospital to release to the Department of Citizenship and Immigration any information concerning my health or medical history, including X-ray films. I also authorize the Department to release information obtained for the purpose of this immigration medical examination to a public health agency or a physician in Canada, if indicated.		**Required for all applicants. Must be taken within six months of the medical examination**
Applicant's Signature	Date Day Month Year	

2. Certification: (If X-ray deferred, provide reason below and return form to examining physician)

If deferred provide reason:

DECLARATION: (IF X-ray is NOT deferred): I certify that I have carried out the X-ray of the person whose photograph and signature are on this form.

Writing Address and telephone number of Location where chest X-ray was taken (please print or use office stamp)

Signature of Technician / Radiographer	Date chest X-ray taken Day Month Year	Place of examination

3. Chest X-ray Interpretation by the Radiologist (general findings)

a) **Skeletal** and/or **soft tissue** abnormalities?	No	Yes ▶
b) **Abnormal great vessel** or **heart shadows**?	No	Yes ▶
c) Abnormal **hilar shadow** and/or lymphatic glands?	No	Yes ▶
d) Abnormal **hemidiaphragms**?	No	Yes ▶
e) Abnormal **lung fields**?	No	Yes ▶
f) **Any evidence of tubercular lesions?**	No	Yes ▶
g) Evidence of **ANY fibrosis/fibrocalcification involving the upper lobes** or superior segments of the lower lobes?	No	Yes ▶
h) Any **other abnormalities**?	No	Yes ▶

Comment on Abnormalities
(if preferred, attach a separate written report)

4. Record of Special Findings Noted on the Applicant's Chest X-ray Film(s)
Please review the list below and check all appropriate boxes

MINOR FINDINGS

- ☐ 1.1 Single fibrous streak / band / scar
- ☐ 1.2 Bony islets
- ☐ 2.1 Apical pleural **capping** with a **smooth inferior border** (< **1 cm. thick** at all points)
- ☐ 2.2 Unilateral or bilateral costophrenic angle **blunting** (**below** the horizontal)
- ☐ 2.3 **Calcified nodule(s) in the hilum / mediastinum** with no pulmonary granulomas

MINOR FINDINGS (OCCASIONALLY ASSOCIATED WITH TB INFECTION)

- ☐ 3.1 **Solitary Granuloma** (< 1 cm. and of any lobe) with an **unremarkable hilum**
- ☐ 3.2 **Solitary Granuloma** (< 1 cm. and of any lobe) with **calcified / enlarged hilar lymph nodes**
- ☐ 3.3 Single / Multiple **calcified pulmonary nodules / micronodules with distinct borders**
- ☐ 3.4 **Calcified pleural** lesions
- ☐ 3.5 Costophrenic Angle **blunting** (either side **above the horizontal**)

FINDINGS SOMETIMES SEEN IN ACTIVE TB OR OTHER CONDITIONS

- ☐ 4.0 **Notable** apical pleural **capping** (rough or ragged inferior border and / or ≥ 1 cm. thick at any point)
- ☐ 4.1 **Apical fibronodular / fibrocalcific** lesions or apical **microcalcifications**
- ☐ 4.2 Multiple / single **pulmonary nodules / micronodules (noncalcified or poorly defined)**
- ☐ 4.3 Isolated **hilar or mediastinal mass/lymphadenopathy** (noncalcified)
- ☐ 4.4 **Single / multiple pulmonary nodules / masses ≥ 1 cm.**
- ☐ 4.5 Non-calcified **pleural fibrosis** and / or **effusion**.
- ☐ 4.6 Interstitial fibrosis / parenchymal lung disease / acute pulmonary disease
- ☐ 4.7 **ANY cavitating lesion OR** "Fluffy" or "Soft" lesions felt likely to represent **active TB**.

☐ **NONE OF THE ABOVE ARE PRESENT**

5. Certification by the Radiologist

DECLARATION: This is a true and correct record of my findings. **IF THE X-RAY LIKELY REPRESENTS ACTIVE TB, THE REFERRING PHYSICIAN WILL BE NOTIFIED DIRECTLY.**

Full name, writing address and telephone number (please print or stamp)		
Signature	Date — Day / Month / Year	Location