Panel Member Instructions

Australian Immigration Medical Examinations

July 2016
These Instructions are prepared in accordance with Australian laws and are for the benefit of the Australian Government. Immigration Health should be advised if any of these instructions contravene or appear to contravene any laws in the Panel country.
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- Notification of local public health authorities
- Notification of the Department
- Notification of the Department
- Post-arrival medical follow up

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Part A: Being a Panel Member for Australian Immigration Medical Examinations

Australia’s Panel Member network (the Panel) consists of physicians and chief radiologists (Panel Members) who conduct Australian immigration medical examinations (IMEs).

Panel Members play an important role for the Department of Immigration and Border Protection (the Department) in conducting immigration medical examinations for people wanting to visit or migrate to Australia.

Physicians and radiologists employed in Australia by the Department’s contracted medical visa services provider are also referred to as the Panel Members in these Instructions.

The Panel Member Instructions (Instructions) for Australian immigration medical examinations will assist you to carry out your responsibilities as a Panel Member.

These will also help you to understand:

- your role and obligations as a Panel Member
- the support you can expect to receive from the Department
- the immigration medical examination requirements
- the standards of service and clinic facilities required.

These Panel Member Instructions are available in an electronic format on the Department’s website at:
http://www.border.gov.au/Busi/Pane/Pane/Conducting-Australian-visas-medicals/instructions

The Panel Instructions are reviewed and updated periodically, but we may send advice of updates or changes in the interim to Panel Members. It is your responsibility to keep yourself informed of the latest version of the instructions and any updates.

1 Who Manages the Panel?

Immigration Health and Immigration New Zealand

The Department and Immigration New Zealand (INZ) have signed a Memorandum of Understanding to align their panel networks and jointly manage the aligned panel. The alignment of the panel network was completed in March 2015.

This alignment provides benefits including:

- efficiency in communication, administration, performance management, audit and training activities to the panel network
- improved client service
- enhanced integrity through robust auditing and analysis
- expansion of TB screening and treatment networks.

This arrangement facilitates INZ implementing electronic processing of its immigration medical examinations via eMedical and supports the broader alignment of Australian and New Zealand immigration health policies and processes.

All aligned panel network sites conduct immigration medical examinations for both countries. INZ has the responsibility for managing the panel network for the South Pacific region (including panel sites in Fiji, Kiribati, Marshall Islands, Nauru, New Caledonia, Tahiti, Tonga, Tuvalu, Samoa, Solomon Islands, and Wallis and Futuna). DIBP manages the panel network for the rest of the world. Both countries independently manage their own panel networks in Australia and New Zealand.

Both countries are independently responsible for managing the processing of results for their respective immigration medical examinations.
The aligned panel network is managed in the aspects of panel administration and performance in their respective regions of responsibilities through:

- managing the number and location of aligned panel sites and Panel Members according to operational needs of both countries and arrangements with our intergovernmental partners (US, UK and Canada)
- conducting desktop and on-site audits of the quality and integrity of the aligned panel’s work
- providing training
- responding to administrative (including access to eMedical) queries from Panel Members
- addressing non-case specific feedback and complaints.

Each country is responsible for communicating their policy, procedural and clinical changes in respect of their health requirements and for addressing case-specific enquiries.

DIBP is responsible for addressing all eMedical system related queries.

Medical Officers of the Commonwealth (MOCs) are located in Australia. They assess IMEs submitted by Panel Members where required and determine if visa applicants meet Australia’s immigration health requirement. This is not the role of the Panel Member.

Role of the Department’s offices outside of Australia

Although Immigration Health retains primary responsibility for managing the Panel, the Department’s offices located at Australian overseas missions (including Australian Embassy, Consulate-General, High Commission or Australian Commerce and Industry Office) take an active role in assisting with:

- monitoring local health issues and trends
- monitoring Panel Member performance
- providing an alternative contact point for Panel Members in emergencies
- conducting clinic site visits
- processing results of immigration medical examinations conducted by Panel Members for certain visas.

2 How to Contact Us

You can contact Immigration Health about any Australian immigration health matter. All eMedical system and immigration medical related enquiries should be made through the Panel Physician Enquiry (PPE) form available both within eMedical under the ‘Contact us’ tab (preferred) and also on the Department’s website.


This includes enquiries for Immigration, Refugees and Citizenship Canada (IRCC), Immigration New Zealand (INZ) or our IT support provider.

The Panel Physician Enquiry (PPE) form can be used for the following queries:

- being unable to logon to eMedical, for example the system is ‘down’ and you have tried again and still cannot access
- other problems with eMedical; for example, you cannot find or submit a case, or users at your clinic do not understand how to use part of the system
- clinical advice in relation to Australian immigration medical examinations or about the Instructions; for example, you want advice about how to grade a particular case or what health examinations are required for a particular client
- information for or approval from Immigration Health; for example, you need to advise us about a change in your clinic details or appoint a locum
for membership of the Australian/New Zealand aligned Panel Physician network
by staff who are eMedical enabled and cannot access eMedical
by staff who are not eMedical enabled and have an Australian case specific enquiry.

Panel Members who do not have eMedical access or cannot access the PPE form on the Department's website can contact us by email. If using email, please ensure that you include your official signature block in your email, including your full clinic name and location. Queries relating to specific cases should include the HAP ID.

Additional contact information is set out below:

**Email:** health@border.gov.au

**Contact hours:** Monday – Friday 9:00 am to 4:00 pm (Australian Eastern Time)

**Fax:** +61 2 8666 5900 / 5901

**Post:** Immigration Health, Department of Immigration and Border Protection, GPO Box 9984, Sydney NSW 2001, Australia

**Website:** [http://www.border.gov.au/Busi/Pane/Pane](http://www.border.gov.au/Busi/Pane/Pane)

**Courier:** Refer to instructions on the Department's website – ‘Where to send Australian immigration medical results’


**Note:** Please do not refer general visa and migration related enquiries to Immigration Health. Please refer to the Department's website for more general information on visas and migration.


**More information about eMedical**

See Part E of these Instructions for advice about the eMedical system and support arrangements.

### 3 Australia’s Immigration Medical Examination Process

**What is Australia’s ‘health requirement’?**

Applicants for Australian visas, and sometimes their non-migrating family members, need to meet the health requirement set out in Australian migration law.

The purpose of the health requirement is to:

- protect the Australian community from public health and safety risks
- contain public expenditure on health care and community services
- safeguard the access of Australian citizens and permanent residents to health care and community services that are in short supply.

To meet the current health requirement, an applicant must be free of:

- active tuberculosis (TB)
- a disease or condition that is or may result in the applicant being a danger to the Australian community
- any disease or condition which, during the applicant's stay in Australia would be likely to:
  - result in a significant cost to the Australian community in the areas of health care or community services
  - prejudice the access of an Australian citizen or permanent resident to health care or community services.
The only medical condition that, in itself, prevents the grant of a visa is active TB, which is specifically prescribed in the Migration Regulations 1994. If an applicant is found to have active TB, they must demonstrate that they have satisfactorily completed a full course of treatment and a MOC must be satisfied that they are not a threat to public health before they can be considered for the grant of a visa. Any person found to have active TB will not be permitted entry to Australia.

The success of this TB screening is reflected in Australia having one of the lowest rates of TB in the world. This low rate has been maintained in the presence of large-scale migration from countries with higher TB rates than Australia, largely because of effective pre-migration screening by Panel Members and the activities of specialised, multi-disciplinary TB services in the states and territories of Australia.

More information about Australia’s immigration health requirement is available on the Department’s website.


**How do I determine what medical examinations are required?**

The immigration medical examination required for each applicant will depend on a number of factors.

These are typically set out in the Migration Regulations 1994 and consideration is made of:

- type of visa
- intended length of stay
- country of citizenship and residence during the previous five years
- age
- any medical issues the Australian Government considers of special significance
- an Australian immigration medical examination undertaken within the last 12 months
- a completed Health Declaration.

In some cases, non-migrating family members who are not visa applicants may also be required to undertake an immigration medical examination.

Decisions about which health examinations are required are made by the Department. For electronic cases, eMedical will list the examinations required. For paper cases this will appear on a letter, such as a HAP letter, generated by one of our IT systems.

If your clinic has been eMedical enabled and the client does not have documentation from the Department about the health examinations required, refer to Part E of these instructions and the eMedical User Guide.

If your clinic is not eMedical enabled and you are concerned that the correct examination has not been requested, please contact us to clarify what is needed. You can also check the health requirements for temporary and permanent visa applications on the Department’s website including requirements for non-migrating family members. Alternately the examinee can contact their visa processing officer/centre, if they have already submitted a visa application.

**Note:** Applicants who are applying for a temporary visa but advise that they intend to apply for permanent residency within the next 12 months should be assessed in the first instance according to the requirements for permanent visa applicants.

**Age milestones**

Health examinations required depend on the age of the applicant. For example, urinalysis is required in those five years of age or older, chest X-ray in those 11 years of age or older, and HIV testing (for permanent applications) in those 15 years of age or older.

Applicants may transition age milestones during the visa process. In these circumstances Panel Members are instructed to perform the health examinations for age related examinations based on the age of the applicant at the time of the consultation.
Which immigration medical examination forms need to be completed?

eMedical enabled clinics must complete the immigration medical examination online using the Department's eMedical system (see Part E of these Instructions).

For clinics where eMedical has not yet been enabled, the following paper forms must be used:

- **Form 26**: Medical examination for an Australian visa
- **Form 160**: Radiological report on chest X-ray of an applicant for an Australian visa

See: [www.border.gov.au/Busi/Pane/Pane/Conducting-Australian-visas-medicals/health-forms](http://www.border.gov.au/Busi/Pane/Pane/Conducting-Australian-visas-medicals/health-forms)

Australian immigration medical examinations

The Immigration Health Branch within the Department is responsible for managing all components of immigration medical examination processing for Australian cases both in Australia and around the world.

Medical Officers of the Commonwealth (MOCs) located in Australia assess all immigration medical examination cases submitted by Panel Members from around the world and determine if visa applicants meet Australia’s immigration health requirement.

The MOCs assess the results, follow up on issues identified by Panel Members, provide advice and address clinical matters as required.

4 Panel Membership

Panel Members are not employees of the Australian Government. They do not represent the Australian Government and those located outside Australia do not have a contractual arrangement with the Australian Government. Panel Members located in Australia are employees or contractors of the Australian migration medical services provider, with whom the Australian Government has a contractual relationship.

Panel Members are required to comply with all conditions of membership issued to them by the Department, including those expressed in these Instructions. These conditions may be reissued or amended periodically and Panel Members will be advised when this occurs.

Visa applicants may attend the Panel Member of their choice and Panel membership does not guarantee a minimum amount of business from the Department.

The Australian Government does not accept any responsibility for any costs associated with membership to the Panel, or loss of business or patronage at a clinic, as a result of:

- changes to the migration programme
- applicants’ choices
- suspension or cessation of panel membership
- any other reason.

The information provided below outlines the specific roles and responsibilities of Panel Members.

Becoming a Panel Member for Australian immigration medical examinations

Physicians and Chief Radiologists need to be assessed for membership and authorised to conduct immigration medical examinations. One or more individual physicians/radiologists at a clinic may apply for membership, but the clinic as a group entity will not be granted membership. However, the membership is specific to a particular clinic site. You must obtain confirmation of continued membership from Immigration Health if you wish to work at another clinic or your clinic relocates.

While membership is related to the individual, the Department takes account of the integrity of the entire practice or entity in which the Panel Member works, including other physicians, staff members, facilities, laboratories and radiology practices. It should be noted that although some aspects of the
immigration medical examination may be delegated to nursing or other staff, the Panel Member retains responsibility for the overall process.

Panel Members are obligated to comply with their ‘Undertaking to Operate within the Bounds of the Australian Panel Member Instructions’ (see Appendix 7) and to protect the privacy of Australian clients with regards to personal information which includes information about their health, in accordance with the Australian Privacy Act 1988 (Commonwealth of Australia).

The Privacy Act defines ‘Personal Information as’…information or an opinion about an identified individual, or an individual who is reasonably identifiable:

(a) whether the information or opinion is true or not; and
(b) whether the information or opinion is recorded in a material form or not.’


Panel Members are to:

• personally carry out a complete and thorough medical examination, impartially grade and submit them in accordance with Instructions
• ensure the quality and integrity of the entire immigration medical examination process
• provide accurate and complete reporting on the health of the examinee
• ensure that specialist service providers, pathology laboratories and TB testing and treatment clinics have access to and understand these Instructions, in particular the integrity requirements
• ensure that specified TB facilities are used where your country is listed in Appendix D
• advise clients of any abnormalities of clinical significance found during the examination
• keep clients updated about the progress of the examinations particularly when these are protracted for any reason
• refer clients requiring treatment, other than emergency treatment, to their usual treating physician
• advise Immigration Health of changes to the Panel Members and panel clinic’s contact details, operating hours, working arrangements and clinic closures and Panel Member’s leave arrangements.

Panel Members are not:

• authorised to oversight medical examinations conducted by non-Panel Members. However, Chief Radiologists can oversight the work of any radiologists nominated to report on applicants’ CXRs
• permitted to provide treatment to clients except in emergencies or in relation to TB (see Part D of these Instructions)
• responsible for providing opinions as to whether clients meet the health requirement. This is the role of the Medical Officer of the Commonwealth (MOC)
• to hand over the original completed medical examination paper forms to the client for submission to Department under any circumstances
• to give their eMedical account logon and password details to anyone else
• permitted to engage in visa related matters.

Note: Panel Members must obtain prior written consent from Immigration Health if a locum or substitute is required (See Page 13).
Panel Clinics

The Department has a preference for clinics where all aspects of the IME which directly involve the client are undertaken at a single site. This includes client registration and other administrative processes (such as taking the photograph in eMedical), the medical examination, specimen (blood and urine) collection, X-ray and all TB related examinations. This improves both client service and the integrity of the process.

Radiologists involved in reporting chest X-rays do not need to be permanently onsite (although this is preferred) but should be available for immediate consultation with Panel Physicians and/or radiographers so that they can provide advice if required.

Use of accredited laboratories

Specimens should always be collected at the panel clinic. Clients should not be referred to the laboratory for this purpose with the exception of sputum collection (see section on Collection of Sputum).

Panel Physicians are responsible for the selection of suitably accredited laboratories to perform HIV and other serological testing. Panel Physicians should have confidence in their chosen laboratory’s security of samples, chain of custody for handling specimens in transport and in the laboratory, use of coding for specimens, that date-expired test-kits are not being used, and that applicants are never able to access their samples or coding information. Original laboratory reports must be provided to the department (either uploaded into eMedical or attached to the Form 26).

Laboratories used for processing pathology specimens must be involved in External Quality Assurance programmes and be able to show evidence of this at onsite audits.

Laboratories used for processing sputum specimens for Mycobacterium tuberculosis require specific expertise in this field. To this end approved TB facilities have been identified in some regions and those are outlined in Appendix D.

The Panel Member examination includes:

- verifying the identity of the examinee (visa applicant/non-migrating family member) presenting for the immigration medical examination using approved identity documentation and recording any inconsistencies in eMedical or on paper form
- a full medical history and comprehensive medical examination
- performing a dipstick urinalysis for the presence of albumin, glucose and blood for clients five years of age and older who are undergoing an immigration medical examination
- personally taking or assuming responsibility for secure specimen collection in the clinic
- arranging for appropriate security or coding procedures to be incorporated into the testing process
- arranging for secure delivery methods for specimens that need transporting to another site as specimens should never be given to applicants to transport
- ensuring that all persons requiring a chest X-ray complete their examination at a panel radiology clinic
- providing accurate and complete reporting on the health status of the examinee
- reviewing the completed chest X-ray examination and report and taking into consideration the findings when grading the immigration medical examination
- submitting all original immigration medical examination reports to the Department, whether by paper or through eMedical, including:
  - immigration medical examination reports
  - radiology examination reports
  - specialist reports
Blood tests

TB screening tests (for children aged from two to 11 years), sputum smears and cultures or other diagnostic test results

Form 160, X-ray film and Form 26 when submitting the results in hard copy.

**Locums**

A locum Panel Member can be authorised to perform immigration medical examinations during periods when Panel Members take leave or to deal with caseload surges. If a Panel Member nominates a physician as their locum they should be satisfied that the physician has the qualifications, experience, knowledge and skills to perform the immigration medical examinations.

An effective handover of procedures must be arranged to ensure continuity of service delivery. Locums will have the same responsibilities as Panel Members and it is essential that Panel Members ensure that locums are familiar with these responsibilities and follow the Instructions.

Panel Members taking planned leave, especially when they are the sole Panel Member in the clinic, should provide a **minimum of four weeks** notice to Immigration Health. We may approve the membership of a locum to cover the leave period of the Panel Member. eMedical access will be provided to the locum Panel Member if the clinic is already eMedical enabled. The locum will require their own eMedical logon.

The documentation required to be approved as a locum Panel Member is the same as for permanent panel membership. Contact Immigration Health if you would like more information on locum membership.

**Radiologists**

The Chief Radiologist at a radiology-only clinic must be a Panel Member. The Chief Radiologist may nominate in writing any other radiologist who will carry out immigration radiological examinations at their facility. This ensures that the Department’s records of health examiners are maintained and radiologists receive access to eMedical where available.

The Chief Radiologist, as a Panel Member, has responsibility for training and supervising all radiologists conducting Australian immigration radiological examinations at that location, including ensuring the accuracy and quality of reports. In most circumstances the Chief Radiologist will be the radiologist who has the most experience in reporting CXR findings for the purposes of Immigration Medical Examinations, and this person may not necessarily be the head of the department. Under the direction of the Chief Radiologist, radiologists, radiographers and clinic staff are required to follow identity checking procedures and to familiarise themselves with the procedures for conducting and submitting radiological examination results.

Where a radiology practice has multiple branches, we will usually approve a single branch/clinic of the practice where all Australian immigration radiology examinations will be undertaken. This arrangement supports the training of staff in the branch/clinic, specifically those related to integrity checking procedures and the correct forwarding of examination results to the department. The Chief Radiologist should be located at this site for most days of the week. The inclusion of additional branches to the Panel will be at our discretion and may require the membership of a Chief Radiologist at each location.

**Chief Radiologists are to:**

- ensure that all nominated Radiologists undertaking Australian immigration radiological examinations are suitably qualified as a specialist in radiology and are registered to work in their country of practice
- provide Immigration Health with the names, date of birth and gender of radiologists they nominate to undertake radiological examinations
- receive feedback about nominated radiologists and staff in their clinic and work with us to resolve cases or issues of concern
- ensure that radiological examinations are conducted only at the agreed site/s
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- put into practice and monitor the procedures for checking identity of examinees
- circulate Immigration Health communications to nominated radiologists and staff
- advise Immigration Health of their clinic’s contact details, capabilities and working arrangements, including any changes to these including significant periods of in-operation
- ensure, for paper cases, that the X-ray examination forms and films are forwarded to the Panel Physician, if the client must also undergo a medical examination.
- ensure that individual radiologists excluded from conducting Australian radiological examinations by Immigration Health do not conduct radiological examinations and report/grade and submit them.

Chief Radiologists and nominated radiologists are to:

- conduct radiological examinations and report, grade and submit for certain applicants who are 11 years of age and older
- conduct radiological examinations for applicants younger than 11 years of age requiring further investigation of TB if referred by a Panel Physician
- provide accurate and complete reporting on the health status of examinees, determined by radiological examinations
- provide an impartial grading on Australian immigration medical examination reports
- advise applicants of any abnormalities of clinical significance found during the examination, or ensure that the Panel Physician does so
- ensure reporting of TB findings and grading is consistent with these Instructions
- refer examinees to a Panel Physician if immediate TB investigation is required.

Medical registration

Panel Members must maintain professional registration and unconditional good standing with their medical board and professional college (if issued by the relevant authority) in their country of practice. Any change to registration status must be reported immediately to Immigration Health.

If a Panel Member becomes de-registered or restricted in their country of practice they must inform Immigration Health immediately and cease undertaking any Australian immigration medical examinations. Panel Members are required to provide evidence of their current registration or licence status during an onsite audit visit or at our request.

Ethical and professional responsibilities of Panel Members

The Australian Government expects all Panel Members to demonstrate a high standard of ethical and professional practice. As a minimum, Panel Members are expected to:

- possess and apply knowledge and skill in the practice of medicine
- observe the professional obligations and codes of practice of the country in which they work
- be courteous and respectful towards applicants, being mindful of their time, dignity, privacy and cultural practices
- ensure that they maintain a productive and professional relationship with all colleagues in health care teams
- display good conduct in professional practice, particularly in relation to conflict of interest and the setting of fees.

Note: Panel Members must not receive or accept service or incentive fees or gratuities of any kind from third parties, including migration agents or referral agencies. If Panel Members accept service, gratuities or incentive fees from any third parties for their services, their Department panel membership may be ceased.
Conflict of interest

As Panel Members provide a service on behalf of the Australian Government, it is important to avoid actual, potential and perceived conflicts of interest. Conflicts of interest have been defined as situations that have the potential to undermine the impartiality of a person because of the possibility of a clash between the person’s self-interest and their professional or public interest. All conflicts of interest and perceived (see note below) or potential conflicts of interest must be fully disclosed to Immigration Health at the time.

Therefore, when conducting immigration medical examinations for the Australian Government, Panel Members must:

• perform the duties of their practice impartially, uninfluenced by fear or favour
• avoid situations in which their private, financial or other interests conflict or might reasonably be thought to conflict with conducting immigration medical examinations
• consider if their commercial and professional relationships with their associated clinics and other third parties, such as migration agencies, present an actual or perceived conflict of interest, and would impact on the independence and reliability of medical reports provided by the Panel Members
• advise Immigration Health of the relationship and potential conflict of interest when the interests of members of their or their staff’s immediate family are involved
• not use information obtained in the course of the immigration medical examinations to gain, directly or indirectly, financial advantage for themselves or for any other person
• not be the treating physician of an applicant, or an applicant’s family member
• if a clinical issue is identified during the course of the IME, the Panel Member should refer the client to their own treating physician. If the applicant does not have a treating physician and wants to remain as a patient at the clinic, then the applicant should be referred to another physician in the clinic. It is acceptable for the second physician to treat the applicant even if they are also a Panel Member, as long as they have not participated in the immigration medical examination of this applicant.

Note: Panel Members must advise Immigration Health of any instances where others may perceive that the Panel Member has a conflict of interest in performing Australian immigration examinations. Examples might include performing immigration medical examinations for friends, relatives or work colleagues. This should be recorded in the “General Supporting Comments” box in the grading section of the 501 examination, or on the Form 26.

Professional development

It is an expectation of membership of the Panel network that individual clinicians maintain currency of knowledge and have ongoing professional development and continuing medical education in place. At a minimum this must meet individual country registration requirements, as well as the expectation that Panel Members will regularly avail themselves of the opportunity to attend migration specific training sessions and summits run by DIBP, intergovernmental partners (USA, UK, Canada and New Zealand) or the International Panel Physicians Association (IPPA).

Disclosure of abnormal health conditions to applicants (Duty of Care)

The IME is tailored to identify medical conditions which will allow MOCs to determine if the applicant meets the health requirement to enter Australia. However, other conditions may become apparent during the examination, and the Panel Member has a responsibility to ensure that follow up and appropriate care is arranged.

In all cases the Panel Member must advise the applicant of any abnormal findings and notify the applicant’s own treating physician when appropriate. It is not appropriate for the Panel Member to undertaken any form of treatment, unless emergency or in relation to TB, as outlined in Part D of these Instructions. The Panel Member’s role is that of an independent examiner who must provide the department with an impartial opinion (see perceived conflict of interest).
If the Panel Member finds the applicant to be seriously ill and in need of urgent treatment, suitable arrangements must be made to ensure appropriate follow up. These might include referral to his or her own treating physician, or to a suitable health facility.

Communication

Panel Members are required to be able to communicate effectively in English. Panel Members must ensure that all reports are completed in or translated into English either by an accredited translator, or by their clinic, or they should provide a clear translation themselves. Reports should clearly show the examinee’s name, date of birth and passport number, and if translation is required, the name of the person who translated the reports.

Providing information to the examinee

Immigration Health requires Panel Members to provide examinees with information about their services such as fees, address, contact details, hours of operation and instructions on how to prepare for the immigration medical examinations. This includes advising them of the duration of the examination, what they should bring with them (for example, previous medical records and glasses or contact lenses) and women should not attend while menstruating. Immigration Health is available to assist you with content to make sure that examinees receive current and appropriate information. We may ask for copies of any written information provided to examinees and it will, usually, be reviewed as part of an onsite audit.

Panel Members must not assist visa applicants with Australian migration information and should refer them to the Department to ensure that they receive accurate information. If the clinic has a website, links to the Department’s website may be published to direct applicants to immigration information and information about the immigration medical examination process.


Note: Panel Members must not use the Australia Government logo, the Department’s logo or eMedical logo on any publications, products or websites to promote their services or Australian migration information. Signs, stamps and signature blocks must not imply that the Panel Member is an employee of the Commonwealth of Australia, or the Department.

Record keeping

eMedical creates an electronic record of all examinations submitted including s. After submitting the case, Panel Members can still view cases they have completed by entering the electronic ID (TRN or HAP ID) of the examinee in the eMedical search field.

Clinics should keep a record of clients they have examined, along with their electronic ID, so that they can access records in the future. This is useful both for internal Quality Assurance, and if the client attends in the future for a new IME. No additional medical records need to be maintained from the Department’s perspective. eMedical records can be printed or saved electronically if required (for example, if the client requests a copy).

It is not possible for Panel Members to review medical cases which have been completed by a different panel clinic, unless the case has been deferred and the client has chosen to attend an alternate clinic to complete the examination.

Panel Members should ensure that the correct information has been recorded and attached in eMedical before submitting the client’s health case. This includes ensuring that the correct photo, identity document information (including passport issue and expiry dates), chest X-ray and reports are attached to the correct client in eMedical, as well as correctly raising any identity concerns where applicable. Grading should also be verified before submitting the case.
Where a health case has already been submitted in eMedical with incorrect information (for example: photo, reports or grading); the Panel Member must report this to Immigration Health as soon as they become aware of this matter.

Panel Members should observe local regulations about medical recordkeeping.

For immigration medical examinations that are recorded on paper forms, Panel Members should keep adequate records including the client’s details and whether an ‘A’ or ‘B’ grading was given. Comprehensive notes and evidence should also be kept of any applicant where significant abnormalities or identity concerns were identified. These records should be kept for a period of at least six months.

Radiology practices are encouraged to keep soft copies (electronic) of digital X-rays.

For monitoring quality assurance, clinics are required to maintain data on a monthly basis on:

- caseload numbers (per clinic and per Panel Member)
- ‘A’/’B’ grading ratios
- detection rates for significant conditions such as HIV and TB (both active and inactive).

In all situations if an applicant requests a copy of the medical record this can and should be provided. In eMedical this is best done through the summary sheet. Applicants can also have a copy of all reports.

**Onsite audit visits and clinical audits**

The quality of Panel Members’ work is regularly reviewed by:

- remote clinical audit of medical and radiological examinations submitted
- onsite audit visits to clinics
- the investigation of feedback received and issues identified.

In accepting membership to the Panel, Panel Members agree to willingly participate in such audits and reviews, and be present at onsite audit visits.

An onsite audit visit will routinely include:

- a review of information and instructions given to clients
- discussion with the Panel Members
- introduction to delegated nurses or administrative staff involved in immigration medical examinations
- a full and thorough inspection of the clinic, X-ray facilities, chest clinic and laboratory (if onsite)
- observation of process including the physical examination and identity confirmation of a client
- an inspection of associated laboratories and chest clinics. Arrangements for offsite visits will ideally be made before the onsite audit.

**Note:** It is expected that Panel Members will be present during an onsite audit and prior notification of absence of key personnel is advised. We appreciate Panel Members’ flexibility when scheduling visits in consideration of the Department’s auditor availability. Onsite visits may be performed by the Department’s staff located at overseas offices and intergovernmental partners in conjunction with or on behalf of the Department.

**Intergovernmental collaboration**

The Australian Government has close ties with its intergovernmental partners (United Kingdom, New Zealand, Canada and the United States of America) in the area of immigration health, and these countries are working together to align their immigration medical examination processes.

Panel Members should be aware that information collected by the Department about the Panel network is routinely shared with these intergovernmental partners. Client information is not shared.
Clients should not be advised to contact the Department in view of using their immigration medical examinations completed for intergovernmental partners for the purposes of Australian immigration medical examinations.

5 Continuity of Membership

Relocation of a Panel Member’s clinic

A panel membership is specific to a clinic. Unless confirmed by Immigration Health, all memberships affiliated with the original clinic automatically ceases upon relocation of the clinic or when Panel Member moves to another clinic. Any immigration medical examinations conducted by the physician at the new location whilst their membership is not current will not be accepted.

Immigration Health is to be advised at least four weeks before the relocation and if acceptable, the Department’s website will be updated and the local Departmental office will be notified of the change in circumstances.

Panel Members should advise changes in their clinic’s contact details to Immigration Health to ensure that these are correct on the Department’s website.

See: https://www.border.gov.au/Busi/Pane/Pane-1

Note: If a Panel Member relocates and proceeds to conduct immigration medical examinations or radiological examinations without prior authorisation, they will be suspended or removed permanently from the Panel (see sections 5.3 and 5.4 of these Instructions).

Retirement or withdrawal of membership

Immigration Health requests a minimum of four weeks’ notice, preferably more, if a Panel Member intends to retire or withdraw their membership from the Panel. Panel Members intending to leave the Panel may be asked to nominate a successor, who will be subject to the usual membership considerations. The Department is unable to guarantee that the nominated successor will be successful in their application for panel membership.

Suspension from the Panel

When the Department has evidence of a breach of procedural integrity or a failure to meet performance standards, non-compliance with Instructions or a failure to meet standards in the completion of immigration medical examinations, Panel Members will be provided notice in writing of this and suspension of their membership will occur.

Immediate suspension may occur in the following situations.

- The Panel Member has failed to identify a condition which may have a significant impact on the Australian community (such as a risk to public health or a significant and serious medical condition such as renal failure).
- There is an allegation of unlawful or serious professional misconduct.

In such cases, the Panel Member will be provided with a written notice of suspension, including the reason for suspension. In cases where an allegation of misconduct has arisen, the privacy and confidentiality of the complainant may not necessarily be disclosed.

Where a Panel Member is suspended for misconduct, they will have 14 days from the date of the notification of suspension to respond in writing to the Director Immigration Health at Health@border.gov.au before a decision is made as to whether the Panel Member will remain on the Panel. Immigration Health’s decision will be final and no further discussion will occur.

Although physicians and the Chief Radiologists have individual membership, the behaviour of everyone in the practice may reflect on the integrity of the clinic itself. Immigration Health may suspend or remove, at its discretion, all of the Panel Members or exclude individual Panel Members, staff or radiologists at a clinic where one person operating from that clinic is under investigation.
In the circumstance where only the Chief Radiologist is suspended or removed from the panel, another radiologist can seek Immigration Health approval to assume the responsibilities of chief radiologist during the suspension period.

**Removal from the Panel**

Membership to the Panel may be revoked at any time at the sole and absolute discretion of the Department. The decision to cancel membership is final and not subject to review. Immigration Health will usually provide four weeks' notice before cancellation takes effect. A shorter notification period may apply if removal from the Panel is for misconduct.

Where there are reasonable grounds to believe that a Panel Member has been involved in matters related to bribery, fraud, the receipt of facilitation fees, criminal activity, offences relating to children or unprofessional conduct, this will result in immediate removal from the Panel.

Panel Members may have their membership revoked on clinical grounds (for example, errors or lack of compliance to these Instructions). If this is being considered, Panel Members will have an opportunity to provide a response before a final decision is made.

Removal from the Panel may also occur where performance issues have not been raised, but there is a decreased need for Panel clinics in a particular region, due to technological developments, reduced visa application volumes, alignment with intergovernmental partners or a change in policy. Immigration Health will make reasonable efforts to give as much notice as possible of any intended changes to Panel composition.

**6 Client Feedback**

The Department has a client feedback policy which allows applicants, their representatives and others to provide compliments, complaints, suggestions or any information about our programme delivery, services or performance.

How clients can provide feedback to the Department

Feedback is provided by:

- Contacting the relevant visa processing officer
- **Online feedback form:** [www.border.gov.au/about/contact/provide-feedback/compliments-complaints-suggestions](http://www.border.gov.au/about/contact/provide-feedback/compliments-complaints-suggestions)
- **Phone:** 133 177 (in Australia only) between the hours of 9.00 am to 4.00 pm (AEDT) Monday to Friday to speak to the Global Feedback Unit
- **Post:** Department of Immigration and Border Protection, The Manager, Global Feedback Unit, GPO Box 241, Melbourne Victoria 3001, Australia
- **Contact an office:**

What a client can do if they are not satisfied with our response?

Clients who ask for a review of how the feedback was handled can contact:

- **Global Feedback Unit** of the Department (see contact details above)
- **Commonwealth Ombudsman**
  - **Phone:** 1300 362 072 (in Australia only – local call charge) 9 am to 5 pm (AEDT) Monday to Friday
  - **Website:** [www.ombudsman.gov.au](http://www.ombudsman.gov.au)
- **Member of Parliament** (in Australia)
Panel clinics and members are also encouraged to have their individual client feedback process either through a survey, suggestion box or other mechanism they may enlist to get such feedback.

7 Complaint Management

What should you do if a visa applicant wants to make a complaint about the immigration medical examination process?

The Department relies on your expertise as a medical professional and your Undertaking to operate within the bounds of the Australian Panel Member Instructions (see Appendix J of these Instructions) and suggest the following approach with a view to resolving any issues that may arise in relation to the medical examination.

- first, try to resolve the problem with the applicant directly by asking them politely what they are concerned about, and:
  - listen to what they have to say
  - if the applicant is upset about action you are taking, explain the reasons for your actions
  - apologise if it is clear that the applicant has received sub-standard service (for example, if a staff member was rude)
  - resolve the problem if you are able to (for example, do not insist on extra tests or referrals, especially if they were not requested by the MOC and note that the test was advised but declined by the applicant).

If they are still concerned, advise the applicant to contact their visa processing office or refer them to the enquiry form found under the Help and Support tab on the Department’s website at: http://www.border.gov.au/about/contact/provide-feedback

Keep a detailed record of what happened and advise Immigration Health of any incidents, particularly if any threats were made against the clinic or clinic staff.

What will Immigration Health do if they receive a complaint?

Immigration Health may request further information from the complainant and/or panel clinic and review all of the information in order to determine if the complaint can be substantiated or not.

Panel Members must not contact the complainant in relation to their complaint without prior consent from Immigration Health. Immigration Health will write to the Panel Member with the outcome of the investigation and advise the complainant that action has taken place. For privacy reasons, complainants will not be provided with specific details of the action taken, if any, against the Panel Member.

- Complaint details will be recorded, including any contact Immigration Health has had with the Panel Member to substantiate the issues raised.
- If the complaint is substantiated and determined to be significant, Immigration Health will seek the Panel Member’s cooperation in addressing the issue. In some serious instances, Immigration Health may consider suspension or permanent removal of that Panel Member from the Panel.

Immigration Health may be approached by third party organisations asking for information about current and former Panel Members, including information pertaining to their performance. Such organisations may include local medical councils and police departments. Panel Members are advised that Immigration Health may, if deemed appropriate, disclose such information, on request, to the bodies described above and to other statutory or regulatory bodies with an interest in medical professional activities. We will usually routinely share this information with our intergovernmental partners: USA, UK, New Zealand and Canada.
8 Client Service

Waiting periods

Clients should be able to make an appointment with clinics outside of Australia within a reasonable timeframe, preferably within 2-3 days. A wait for appointment must never be longer than 10 working days.

The waiting periods for Panel clinics in Australia must be consistent with the agreed contractual service standards. Panel Members are required to advise Immigration Health when timeframes are delayed longer than five working days and if they are experiencing issues managing appointments.

Clinic facilities and hygiene

Clinics should make reasonable efforts to facilitate access to their premises and promote the comfort of clients. As a minimum standard, Panel clinics should meet the following requirements:

- a reception or waiting area large enough to accommodate the usual number of clients and other people waiting
- toilets with hand cleaning facilities, located in the clinic itself. Toilets not in the clinic must be adjacent to or in very close proximity as applicants will need to be supervised when providing urine samples.
- heating and/or air-conditioning, where appropriate.

Acceptable standards of cleanliness must be evident in the clinic and the amenities used by clients.

Medical clinics

A dedicated consultation room or area must be available for the exclusive use of the Panel Member and delegated nurse (if used). It must not be open to the public or shared with other staff during the examination. Each consultation room or area must have as a minimum:

- adequate lighting
- an examination couch
- medical equipment appropriate for an immigration medical examination
- access to a properly maintained specimen fridge (if the pathology laboratory is offsite), which includes a log of fridge temperature
- hand-cleaning facilities readily available
- facilities to protect the applicants’ privacy when applicants undress, including use of an adequate curtain or screen, gown and privacy sheets
- a facility for safekeeping of the client’s possessions.

Radiology clinics

Radiology clinics must have as a minimum:

- adequate and well-maintained radiology equipment
- appropriate personal protective equipment
- radiation safety guidelines
- abdominal lead shielding which should be used for all applicants (see radiology section)
- facilities to protect the applicants’ privacy when applicants undress including use of an adequate curtain or screen, and gown
- a facility for safe-keeping of applicants’ possessions.
Duration of medical examinations

The immigration medical examination must be comprehensive, thorough and complete. Immigration Health anticipates the physical examination alone of young, healthy individuals with no significant medical history to take at least 15 minutes. For an elderly person, or someone with a complex medical history, the examination is likely to take up to 60 minutes.

Cultural, gender and language aspects of examinations

Panel Members should be aware of cultural and gender based expectations in relation to immigration medical examinations and history taking. If examinees do not speak the language of the Panel Member, arrangements are to be made for an interpreter.

Note: The Panel Member must be satisfied as to the interpreter’s impartiality, confidentiality and ability to interpret accurately. The interpreter should not be a family member or representing agent due to a potential conflict of interest, and to avoid risk of misinformation leading to misdiagnosis.

Privacy considerations

To prevent misunderstandings, clients should be given information about what will happen during the immigration medical examination when they make an appointment including the need to undress, to their underwear, for the physical examination.

Aspects of the immigration medical examination that may make clients uncomfortable, such as breast examinations for women, must be made known to the examinee at the time the appointment is made, as well as on arrival at the clinic and before the examination starts.

Appendix E provides a diagram that you may wish to include when giving the client information about the immigration medical examination and/or to display in your clinic waiting room, change and/or examination room.

Chaperones

All physical examinations should be conducted in a professional manner compatible with good practice and privacy. A parent or guardian must be present when a child is examined or X-rayed. A chaperone must be offered and available during the physical examination for all applicants and provided at the expense of the Panel Member. Particular attention should be taken with female examinees. Even when a female family member accompanies a female client, it is advisable to have a female member of the clinic staff present.

Details of the offer and presence of a chaperone must be accurately recorded in eMedical and on paper forms.

Children for adoption

Panel Members should be particularly careful to avoid any conflict of interest situation developing in the context of adoption cases. Panel Members should not conduct immigration medical examinations on children from orphanages with which they are associated. In the absence of alternative Panel Member options, any such associations should be declared to Immigration Health for approval, prior to the immigration medical examination.

Immigration medical examinations of children for adoption visa applications have special requirements, and Panel Members should take care to ensure that these requirements are met. Section 36, Human Immunodeficiency Virus (HIV) and section 37, Hepatitis B and C, in Part B of these Instructions provides further details of these requirements.

Children requiring specialist assessments should not be referred to specialists associated with the orphanage.
Pregnant women and X-ray examinations

CXRs are the routine method to screen female applicants, who could be pregnant, for TB. Panel Physicians must ask female applicants of childbearing age about pregnancy and the last menstrual period.

Almost all imaging tests expose the foetus to such low levels of radiation that they are not a cause for concern. The International Commission on Radiological Protection (ICRP) has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation.

Any radiological examination of the mother that does not involve the direct irradiation of the foetus will deliver a comparatively low dose to the foetus. (Ref: HPA: Protection of Pregnant Patients during Diagnostic Medical Exposures to Ionising Radiation (RCE-9) March 2009.)

The ICRP has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation. If the pelvis or abdomen is not in the direct beam the foetal dose is usually <1 mGy. The typical foetal dose of a CXR is 0.001–0.01 mGy.

People are exposed to background radiation in their daily activities which varies widely in different parts of the world due to the radioactivity of the soil, latitude, height above sea level and lifestyle (predominantly indoors or outdoors).

Applicants from lower TB risk countries are not required to complete a chest X-ray if pregnant. If the clinic is eMedical enabled, in the 502 CXR examination pregnancy declaration, the requirement can be set aside and the case submitted.

Applicants from higher TB risk countries who are pregnant should be advised that they have the option of either:

- deferring their chest X-ray, and therefore the finalisation of both their health clearance and visa application, until after giving birth, or
- proceeding with the chest X-ray examination, with appropriate abdominal lead shielding, after completion of the first trimester.

Prior to a pregnant examinee making a decision to proceed with the chest X-ray, a full explanation of the risks must be provided by the Panel Member or the pregnant client’s treating physician/obstetrician. If, after a full explanation of the risks the pregnant client elects to undergo a chest X-ray, the following guidelines must be followed:

- The client must complete the consent form.
- The field size must be strictly limited to include the chest area only (the field is not to include the abdomen or head).
- Double lead wrap around abdominal and pelvic shielding must be used.
- The radiology clinic must confirm on the paper chest X-ray examination report (Form 160) or using the specific form in eMedical, that informed consent has been obtained.

Pregnant clients from high TB burden countries who choose to postpone the X-ray requirement until after childbirth

For eMedical cases, if the question “has the pregnant woman advised that she wishes to proceed with the required examination?” is answered "no", then a pregnancy deferral letter will be generated and the case will remain pending (status set to "on hold") until the applicant returns for the chest X-ray after pregnancy. eMedical enabled clinics must provide these applicants with the ‘pregnancy deferral letter’ that is generated via eMedical to confirm this and present to their visa processing officer.

For paper cases, a reference should be made on the paper Form 26 to the presence or absence of any history or clinical evidence of TB and the countries in which the pregnant client has lived in the past five years, and the case submitted. It should be graded ‘B’.
9 Setting Fees for Australian Immigration Medical Examinations

Panel Members outside Australia are not contracted to or paid by the Australian Government for providing immigration medical examinations. Panel clinics will charge clients directly for examinations conducted by Panel Members and it is the responsibility of the client to pay the fee for an immigration medical examination. Different payment arrangements exist for Refugee and Protection visa applicants and Panel Members should seek clarification with Immigration Health or the local Australian Immigration office if required for such referrals.

The Australian Government does not routinely prescribe a fee structure. However, it is the responsibility of the Panel Member to ensure that fees charged are consistent with local charges for similar services. Fee structures well above or below local market rates are not acceptable and will be investigated by Immigration Health.

Fee schedules must be transparent and should be itemised by standard examination type – 501, 502, 707, 708, 716, 719, as well as bundled fees (501/502 or 501/502/707). An example template is offered below.

<table>
<thead>
<tr>
<th>Item</th>
<th>eMedical Requirement Code(s)</th>
<th>Fee</th>
<th>Example Applicant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examination</td>
<td>501</td>
<td></td>
<td>Child migrant, Aged visitor</td>
</tr>
<tr>
<td>Medical + Chest X-ray</td>
<td>501 + 502</td>
<td></td>
<td>Student (non-healthcare), Working Holiday Makers and long term visitors</td>
</tr>
<tr>
<td>Medical + Chest X-ray + HIV</td>
<td>501 + 502 + 707</td>
<td></td>
<td>Migrant (such as Partner, Parent, Skilled Migrant)</td>
</tr>
<tr>
<td>Medical + Chest X-ray + HIV + Hepatitis B/C</td>
<td>501 + 502 + 707 + 708 + 716</td>
<td>Healthcare worker or healthcare student</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Tests</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV test</td>
<td>707</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>708</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>716</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB screening test</td>
<td>719</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fees should be all inclusive without any extra charges such as ‘administration fees’. Panel members should be aware of the department’s position on the charges related to TB investigation and treatment (see below) and that these charges should be incorporated into the overall cost of the IME and individual clients should not be required to pay additional charges for any part of this additional process. This additional cost should therefore not require to be itemised separately.

Additional standard examinations 901 – 904, mini-mental state examination (MMSE) and Activities of Daily Living (ADL) assessments should be factored into the pricing of the 501 requirement and covered by the initial fee. There should be no extra charge for completing these examinations.

Applicants should be advised of standard examination fees in advance, including any postage/courier costs for paper cases. Fee schedules must be clearly displayed in the Panel Member’s reception area and on the panel clinic’s website and be advised to applicants when arranging their appointment.

Courier Charges

Clinics that are not eMedical enabled may charge courier costs for the delivery of paper forms. They should then provide the courier reference number so that the applicant can track the delivery of their documentation. Any charges for courier services/delivery must be itemised on the applicant’s invoice.

Standard fees and actual courier charges should be paid before the examination. Fully itemised receipts must be issued for each appointment listing the charges.

Applicant fees for Panel clinics located in Australia are managed through the contractual relationship between the migration medical service provider and the Department.
Costs associated with further TB testing and treatment

Financial burden on an individual, for the cost of further TB investigation and treatment, is not supported by the Department as it may act as a disincentive to clients to proceed with testing that is in their own interests. The Department therefore requires that panel clinics institute a system whereby an individual client, who requires further investigation to exclude active TB and TB treatment, if required, will not be financially burdened.

Immigration Health stipulates that Panel Members will undertake that their clinic will be responsible for all associated costs. DIBP do not make recommendations on how this might be achieved. Some clinics have a mechanism that allows them to recoup this from across the entire caseload through a minor variation in fees that is applied to every applicant attending for an immigration medical examination.

The costs of smears and culture, DST and treatment vary from country to country. Costs of investigation and treatment will cover all aspects, including pre-treatment workup, specialist fees, medication, provision of Directly Observed Therapy (DOT), sputum and radiology monitoring during treatment, Panel Physician review, and post treatment chest X-ray. Further information is provided in Part D.

Clinic accounts for managing the costs around this process should be transparent and will be subject to review by Immigration Health. Please contact Immigration Health if you would like further advice.

10 Maintaining the Integrity of the Medical Examination

Panel Members are accountable for the integrity of all facets of the immigration medical examinations including those conducted outside the Panel clinic, that is, specimen collection at an offsite pathology centre or at a specialist consultation.

If a Panel Physician delegates minor parts of the immigration medical examinations (that is, height, weight, visual acuity measurements or urinalysis), these elements must be performed by a staff member for whose work the Panel Physician will take responsibility.

Likewise radiologists are accountable for the integrity of all facets of the chest X-ray examination. Where elements are performed by a qualified radiographer, the radiologist must take overall responsibility for this delegation. The Chief Radiologist is responsible for the integrity of all the work performed by the radiologists and radiographers.

Confirming identity

Panel Members and their clinic staff must confirm the identity of all individuals who present for an immigration medical examination and record all identity concerns for follow up by the Department. This is done by completing the identity questions included in paper forms or on eMedical.

Note: Panel Members must also ensure that the appropriate identity-control mechanisms are in place at all specialists clinics to which the examinee is referred, as well as all pathological laboratories, TB testing laboratories and treatment programs. eMedical referral letters should be used where possible.

Informed Consent

All applicants agree to undergo health aspects of the visa application process, either as part of their visa application, in eMedical, or on the paper form 26/160.

A parent or guardian (necessary evidence may be required to verify this relationship) should sign on behalf of an examinee who is under 16 years of age (local laws may need to be taken into account in respect of the relevant age) or who is deemed an ‘incapable person’. An ‘incapable person’ is defined as a person who is incapable of understanding the general nature, effect of, and purpose of the requirement for providing a signature. Such people may include those with an intellectual disability.

If children are subject to custody arrangements, then Panel Members may need to obtain consent from both parents or guardians. Panel Members should make themselves aware of local regulations in this regard.
What forms of identity documents are acceptable?

A valid **original passport** is the Department’s primary and preferred form of identity documentation. In exceptional circumstances where this is unavailable, limited alternative identity documentation is acceptable as outlined below and in the options that are available to your clinic when confirming the identity of examinees in the eMedical system. Please note that for UNHCR referred refugees the UN identity document will be accepted.

<table>
<thead>
<tr>
<th>Alternative identity documents that can be selected in eMedical</th>
<th>When will this option be available</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAP Letter* and Certified Passport Copy**</td>
<td>For all cases</td>
</tr>
<tr>
<td>HAP Letter* and Photo (Stamp)***</td>
<td>For all cases</td>
</tr>
<tr>
<td>HAP Letter* and National ID Card</td>
<td>If the issuing country that you select for the identity document is one where the Department permits national ID cards to be used for eMedical identity purposes (listed below).</td>
</tr>
<tr>
<td>National ID Card and Certified Passport Copy**</td>
<td></td>
</tr>
<tr>
<td>National ID Card and ID5</td>
<td>This option will appear for Panel clinics in China only.</td>
</tr>
</tbody>
</table>

* This must be a Health Examinations List (HAP letter) or equivalent documentation on the Department’s letterhead or an email which contains the applicant’s personal details and lists their required health examinations.

** This must be a photocopy of the photo/personal details page from the applicant’s passport that has been certified by the Department or a contracted Service Delivery Partner (SDP) of the Department.

*** The HAP letter must have a recent colour photograph of the applicant attached that has been officially stamped by local Australian overseas mission certifying the applicant’s identity.

**Note:** Only National Identity Cards from the following countries are acceptable. Panel Members in countries not listed below should **not** accept identity cards unless otherwise advised by Immigration Health in writing.

<table>
<thead>
<tr>
<th>Albania</th>
<th>Czech Republic</th>
<th>Italy</th>
<th>Singapore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Egypt</td>
<td>Malaysia</td>
<td>South Korea</td>
</tr>
<tr>
<td>Brazil</td>
<td>France</td>
<td>Netherlands</td>
<td>Spain</td>
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<tr>
<td>Bulgaria</td>
<td>Germany</td>
<td>Pakistan</td>
<td>Sweden</td>
</tr>
<tr>
<td>Canada</td>
<td>Hong Kong</td>
<td>Poland</td>
<td>Taiwan</td>
</tr>
<tr>
<td>China</td>
<td>Hungary</td>
<td>Portugal</td>
<td>Thailand</td>
</tr>
<tr>
<td>Croatia</td>
<td>Indonesia</td>
<td>Russia (internal passport)</td>
<td>Turkey</td>
</tr>
</tbody>
</table>

**Note:** Australian Visa Application Centres **do not** include migration agents or in-country education agents. To find out who the service delivery partner of the Department is in your country, see the Department’s website.

Under current contractual arrangements, the onshore migration medical services provider is not able to accept identification other than a current passport, except in circumstances where this is authorised by the Department. Specific agreed arrangements are in place. These include the case officer sending an approved form with the applicant’s photograph directly to the onshore migration medical services provider. Details of these arrangements are available in the *Procedural Advice Manual 3: Sch4/4005-4007: The health requirement.*

If you are unsure about an identity document presented, please contact Immigration Health.
Are there any exceptions?

There are two scenarios where the immigration medical examinations can proceed if the client does not have an original passport or any of the approved alternative identity documentation outlined above.

**Scenario 1 – the client is a non-migrating family member**

As these clients (often children) will not be migrating to Australia with the visa applicant they may not have a passport or other accepted alternative documentation. Consequently, for these clients you may accept other documentation, for example: a birth certificate, school registration documents or student card. The Department would usually expect more than one form of identification to be provided and preferably one that contains a photo of the client.

**Scenario 2 – Immigration Health approval obtained**

The only other scenario in which you can proceed with an immigration medical examination in the absence of an original passport or other approved alternative documentation is if you have received advice from Immigration Health to proceed. Immigration Health will contact you or your clinic directly before the client’s appointment if they are aware. If such advice has not been received, you should advise the client to contact their visa processing officer/centre or the local Australian overseas mission before you proceed with their immigration medical examination.

In these two scenarios, you can select ‘Other’ in eMedical, raise an identity concern and proceed with their immigration medical examination.

**Note:** Scan and upload any documentation that is presented. Information about X-ray requirements for non-migrating relatives can be found in Part C of these Instructions.

Should you need further advice about proceeding with a particular examination or have feedback about identity issues, contact Immigration Health. Clients can be referred to the Department’s website for more information about identity requirements.

**See:** http://www.border.gov.au/Trav/Visa/Heal/Meeting-the-health-requirement/Arranging-a-health-examination

When should I record an identity concern?

Identity concerns are **not** only in relation to clients who are attempting to engage in fraud as part of their visa application process. You should raise an identity concern if:

- the applicant provides you with a number of identity documents that appear inconsistent
- you are concerned about the authenticity of any/all of the identity documents provided
- the person’s physical appearance appears to have significantly altered from that which appears in the identity document, for example this may be the case for clients who have undergone gender change or cases involving cosmetic surgery
- the person who is presenting for the immigration medical examination does not appear to be the person in the photo(s) of the identity documents provided
- the applicant’s personal or identity details in eMedical are ‘**substantially different**’ from the identity documentation that the applicant has provided you.

The table below provides more detailed advice about when details in eMedical are considered by the Department to be ‘substantially different’ and when an identity concern should be raised and a scanned copy of the identity documentation attached in eMedical.

<table>
<thead>
<tr>
<th>Identity concern MUST be raised when:</th>
<th>Identity can be verified (that is, NO identity concern required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Surname do not match between passport and what is provided in eMedical (that is, the names are significantly different)</td>
<td>There are minor name/spelling differences between the passport and what is provided in eMedical (for example: hyphen present/absent; middle name not entered; variations in how name is entered – for example, name and surname all on one line)</td>
</tr>
<tr>
<td><strong>Identity concern MUST be raised when:</strong></td>
<td><strong>Identity can be verified (that is, NO identity concern required)</strong></td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Gender is different in passport/reality to what is in eMedical</td>
<td>Gender is not recorded in eMedical (that is, is unknown)</td>
</tr>
<tr>
<td>The country of birth is completely different on the passport and what is provided in eMedical (for example, Passport = Lebanon and eMedical = USA)</td>
<td>The country of birth does not appear in eMedical.</td>
</tr>
<tr>
<td>There are very minor differences in how the passport number is recorded on the document as opposed to eMedical (for example, eMedical has a ‘space’ in the field and the passport does not, that is, AC 123456 vs AC123456)</td>
<td>There are very minor differences in how the passport number is recorded on the document as opposed to eMedical (for example, eMedical has a ‘space’ in the field and the passport does not, that is, AC 123456 vs AC123456)</td>
</tr>
<tr>
<td>Any difference in the date of birth</td>
<td>There are discrepancies in relation to the passport issue date or expiry date information, or this information is not appearing in eMedical</td>
</tr>
<tr>
<td>Any difference in appearance of applicant with photo on the Passport, ID card or HAP letter</td>
<td>The passport number and/or issuing country are not appearing in eMedical.</td>
</tr>
<tr>
<td>If the appearance has changed purely due to age or because of medical procedures or accidents. Note where the appearance does not appear consistent with the date of birth this should be flagged as an identity concern.</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Raising an identity concern in eMedical does not mean that any action will be taken against the client – It is simply an alert for the Department to ensure that the Departmental officer processing the visa application will address any data or identity issues before finalising the visa application.

If you reasonably suspect that the person presenting for immigration medical examination is not the client or visa applicant and may be an imposter please contact Immigration Health. Any evidence that supports your identity concerns should be attached to eMedical or paper forms.

**Digital Photo**

As a part of the pre-examination stage in eMedical, clinics are required to capture a digital facial image in colour of each examinee at the time of their appointment and then upload the image to their case in eMedical. Clients are no longer required to bring passport size photographs with them to their appointment and **this should not** be requested by eMedical clinics.

A scanned image of a photograph must **not** be uploaded because a scan is not a true image of examinee’s facial features. The photographs uploaded in eMedical are used for identification purposes during the visa application process and verified against other information in Departmental systems. It is therefore important that photographs uploaded in eMedical are of biometric standard. More information on eMedical and reference materials can be found in Part D of these Instructions and in the eMedical Capturing Facial Images tip sheet. Use of a tripod, appropriate lighting and with the applicant sitting will improve photos. Photos should never be “cropped” but adequate zoom at time of picture capture should be employed.

**Note:** Photos uploaded to eMedical should be clear and correct. Submitting health cases in eMedical with incorrect photos could result in adverse auditing findings against your clinic. Continuing to submit incorrect photos is a performance issue and may lead to suspension.
11 Specimen Integrity

Panel Physicians should perform specimen collection onsite. If the Panel Physician delegates this procedure to a nurse or phlebotomist, the Panel Physician remains accountable for the integrity of this part of the examination.

Correct specimen collection will entail:

- confirming the identity of the examinee
- explaining the collection procedure to examinees
- using appropriate disposable equipment
- safe storage and disposal of clinical waste including sharps
- disinfecting the area of skin for venepuncture and using personal protective equipment (and not re-contaminating)
- urine collection in a secure setting in very close proximity
- urine dipstick testing onsite
- accurate specimen identification using non-removable labels
- incorporating appropriate security or coding procedures into the testing process for specimens and laboratory requests
- ensuring all pathology test kits are not beyond expiration dates
- refrigeration of specimens or transportation to the laboratory within one hour
- maintaining specimen integrity during storage
- where necessary, ensuring secure transportation (including the container) with a laboratory request for specimens; specimens must never be given to clients for transport
- participation in external quality-assurance programme.

12 Disclosure of Abnormal Health Conditions to Examinees

In all cases, Panel Members have a duty of care and must advise the examinee of any abnormal findings. There may also be some circumstances where it is appropriate to notify the treating physician. Where an abnormal condition is suspected pending verification through further testing, the examinee should be provided sufficient detail of this and any concerns raised should be addressed.

Note: Except for TB treatment (refer to Part D of these Instructions), under normal circumstances it is not appropriate for the Panel Member to give any form of treatment in relation to the client. A Panel Member must not enter into a therapeutic relationship with the client. The Panel Member’s role is that of an independent examiner who is to provide the Department with an impartial assessment of their findings.

However, if the Panel Member finds the client to be seriously ill and in need of urgent treatment, the Panel Member must inform the client and refer them to his or her usual physician, or to an appropriate specialist or medical facility. Panel Members should record any counselling and referral action taken in relation to serious medical conditions in the general supporting comments field in eMedical.

13 Further Tests and Specialist Referrals

Although Panel Members may directly refer clients to specialists, the only conditions for which such referrals are routinely and immediately required are:

- strong suspicion of active TB
- 707 (HIV) examination is positive.
In general, conditions that are not public health risks and do not need acute medical care will not need initiation of specialist referral by the Panel Physician. In such cases, the immigration medical examination case should be submitted for MOC assessment. The MOC will advise if any additional investigation is needed. Electronic medical processing means that the turnaround time for advice to applicants is relatively brief.

Part B of these Instructions does, however, identify limited further circumstances where specialist reports should be obtained by Panel Members because the Department will likely require extra information, and/or there is a clinical need for immediate management, such as where a delay in diagnosis or treatment will result in adverse health outcomes (for example, suspicion of malignancy). In some cases eMedical will auto generate a request for additional information.

When making external referrals, Panel Members must explain to clients why further investigation is needed. Panel Members should also explain that the results will be sent from the specialist to the Panel Member who must submit the reports to the Department, although clients should also be offered a copy. Specialist referral letters can be generated via eMedical.

The choice of a specialist is not limited; however high-quality reports are needed, as substandard reports will not be accepted by the Department, Panel Members should refer clients only to specialists in whom they have confidence in clinical skill and reporting. In some locations, approved laboratories and specialists must be used for investigation and management of TB. A list of these locations can be found at Appendix D.

All examinees should be explained in depth the timeframe for TB screening, results and treatment. It is important that the reason and process is explained as this is a common source of client complaints.

Panel Members should ensure that the specialists:

- confirm the identity of the client against their passport
- provide detailed reports in English, if possible, including results of all necessary investigations and a description of the recommended management and likely prognosis of the condition.

Forwarding specialist reports

Original specialist reports are to be sent directly to the Panel Member, who should then scan (if hard copy) and attach to eMedical or forward to the Department (paper cases only). Specialist reports should clearly show the client’s name, date of birth and passport number and HAP ID. Reports not in English should be translated as outlined above.

Any specialist reports provided by the client from a specialist of their choice should be attached to eMedical or the paper forms.

14 Grading

Panel Members are required to grade immigration medical examinations as ‘A’ if no significant medical conditions, in respect of migration, were identified, and ‘B’ if a significant medical condition has been identified. A ‘B’ grading does not mean that the applicant will not meet the health requirement or will be refused a visa because these decisions are not made by Panel Members.

When an abnormality is detected or declared, Panel Members must provide sufficient detail on the nature, severity and possible prognosis of the medical condition so that the MOCs are able to clearly understand the client’s state of health and the relative significance of the medical condition. Comments from Panel Physicians are required on how each medical condition currently affects, or is likely to affect, the client’s normal daily functioning, level of independence and fitness for work.

15 Submitting Immigration Medical Examination Results

Submitting in eMedical

Immigration medical examinations completed in eMedical will be submitted automatically to the Department once all required health examinations are completed. There is no manual document handling required. Refer to Part E of these Instructions for more information on eMedical.
Immigration medical examination results must be submitted without delay and within a maximum of three days of the examination, unless additional examinations are required (such as specialist review). Clinics have a responsibility to manage their pending caseload to ensure prompt submission of cases and to avoid any delays and inconvenience to applicants.

eMedical enabled clinics must not submit paper forms unless exceptional circumstances exist. Clinics will be asked to provide an explanation if they submit paper forms and they are already eMedical enabled.

Submitting paper forms

Panel Members using paper forms for the immigration medical examination must check their completeness and correctness before submission, including confirmation of the client’s identity and the client declaration. Panel Members should check that:

- the current version of the form (26 or 160) is used
- the health examination results and comments are completed in English
- forms are signed by the client and the Panel Member (forms completed and signed by non-panel members will not be accepted)
- any additional reports and the CXR film (clearly identifying the client) are attached to the forms 26/160 as applicable.

Where to send completed paper forms

Panel clinics outside Australia that are not eMedical enabled have only two destinations to select from to send paper forms. Forms must either be sent to the Department’s local office at an Australian overseas mission (Embassy, Consulate-General, High Commission or Australian Commerce and Industry) or to the Immigration Health courier address in Australia.

**Important:** The envelope should be prominently marked “CONFIDENTIAL – MEDICAL RECORDS”.

For more information on where to send completed paper forms, refer to ‘Where to send paper health examination results for Australian visas’ on the Department’s website.

**See:** http://www.border.gov.au/Busi/Pane/Pane/Conducting-Australian-visas-medicals/where-to-send-australian-immigration-medical-results

Panel Radiologists should send the completed chest X-ray examination Form 160 and related films directly to the examining Panel Physician so that they, in turn, can complete the immigration medical examination, and forward the complete records to the Department.

Documents and reports should not be stapled to the chest X-ray films. Chemically developed films should also be dry before they are handled and must be kept flat when prepared for dispatch.

**Important:** All completed paper forms, together with test results, specialist reports or specimens are the property of the Commonwealth of Australia. Under **no circumstances** must **original** records be given directly to clients, their representatives or other parties. The Department will **not accept** documentation sent this way.

Upon request, Panel Members can provide a client with copies of any forms, diagnostic reports or test results without permission from the Department. Panel Members are able to charge a fee for this service, but it must be clearly displayed in the clinic reception area. A fee should **not** be charged for medical information that is required to be given by the Panel Member in relation to the applicant’s ongoing care with their family physician or specialist. Alternative arrangements exist in relation to refugee health.

Copies of medical records and reports should **not** be provided to family members, migration agents, or anyone else, without the express written permission of the client.

If an applicant has any queries in relation to their immigration medical examination, Panel Members should refer the applicant to their visa processing officer/centre.
Incomplete immigration medical examinations

Immigration medical examinations which have already commenced should not be kept pending indefinitely while waiting for clients to send new information or to complete tests, even if the case is awaiting identity verification only.

If a client:
- indicates that they are withdrawing from the application process
- does not proceed with the immigration medical examination due to medical conditions which they feel will make them unlikely to meet the health criteria
- has not returned to complete any other additional examination requested by eMedical or by MOCs, within four weeks
- has not supplied requested information within four weeks of the request, and the Panel Member has not been informed of credible difficulties in obtaining the information
- has not completed investigation for TB or returned for treatment.

The Panel Member must:
- complete the examination(s) with the available information
- record the relevant questions as abnormal
- select ‘Finalise Incomplete’ against the relevant examination in eMedical
- state the reason/s for not completing the immigration medical examination process including all attempted contact with the client in the general supporting comments field and under the “Finalise Incomplete” box.

For incomplete examinations at non-eMedical enabled clinics using paper forms, the Panel Member must:
- clearly mark the front of the form as ‘Incomplete immigration medical examination
- send all the partially completed documents to the Department.

Declaration by examining Panel Physician

In making a declaration in relation to paper cases:
- the Panel Physician’s name must be printed or stamped clearly on Form 26. The name must be that which was provided to Immigration Health in the panel membership application. The use of all other versions of a Panel Physician’s name (such as aliases) is unacceptable.
- the Panel Physician must sign the declaration once the results of the physical examination are recorded fully and the Panel Physician has completed his or her comments on the examination and on any additional reports and tests which may have been performed.

In signing the declaration or submitting the case on eMedical, the Panel Physician is acknowledging responsibility for the integrity and quality of the entire immigration medical examination process.

16 Other Panel Physician Roles

Immunisation

With the exception of some specific client groups (such as refugees) it is not mandatory for Panel Physicians to provide immunisations. Immunisations are not currently required as part of the immigration medical examination, unless special arrangements apply.

Parents are, however, strongly encouraged to consider immunising their children against hepatitis B, diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, haemophilus influenzae type-b (Hib),
pneumococcal and meningococcal infections, mumps, measles, rubella and varicella (chickenpox). Rotavirus vaccination is encouraged in infants between two and eight months of age.

Panel Physicians should counsel parents accordingly and advise them to complete outstanding immunisations before they travel to Australia. Physicians should advise parents to take their children’s records of immunisation to Australia as these will be required for school enrolment and other settlement related purposes, including family benefits.

Rubella vaccinations are strongly encouraged for women of child-bearing age (unless they are pregnant).

For more information, clients can be referred to the following Australian Government websites:

Communicable disease

In response to potential threats of importation of communicable disease, the Department at times, and in the interests of public health, may request the assistance and cooperation of the panel to implement specific measures to assist in managing risk. The Department would, in such cases, issue specific instructions to panel members, which may include additional screening, vaccination and/or certification of existing immunisation certificates.

Further information can be found on the Australian Department of Health website: (www.health.gov.au). Information relating to poliomyelitis can be found at the following:

Yellow fever

Panel Physicians should alert the applicant to Australia’s entry requirements for yellow fever. Panel Physicians should advise applicants that all people older than one year of age who have stayed overnight or longer in a declared yellow fever infected country within six days before arriving in Australia are strongly advised to hold an international Yellow Fever Vaccination Certificate.

Panel Physicians should ask applicants if they have been vaccinated against yellow fever and hold an international yellow fever vaccination certificate. Panel Physicians are also required to explain to applicants that they will be required to present this certificate upon arriving in Australia. In instances where vaccination is medically contraindicated or they do not hold a certificate, applicants should be advised that they would not be refused entry. Rather, on entering Australia, they will have a short interview at the border and be provided with a Yellow Fever Action Card.

More information on Australia’s requirements for yellow fever vaccination, including the list of yellow fever declared places, can be found at the following Australian Government website.
For information, please refer to the Department’s website – in particular ‘Threats to public health’ at:

DNA testing

The Department may ask Panel Physicians to undertake DNA sample collection in liaison with a nominated DNA testing laboratory in Australia. You will be advised of requirements by the visa processing office when it is required.

Counselling guidelines

The following guidelines have been produced to assist Panel Physicians when counselling clients who have genetic (DNA) testing for the purposes of verifying claimed family relationships.
Pre-test counselling

Before DNA testing is performed, pre-test counselling should be provided to the client by the Panel Member collecting the sample.

The Panel Member should explain:

- undergoing DNA testing is voluntary for the client
- how samples will be collected
- the test is used to determine biological relationships
- the results of the test will be accurate and reliable in determining biological links between the clients and are considered conclusive in parentage-testing case.
- counselling options for clients should results show unexpected biological results.

Post-test counselling

If the results of a DNA test show unexpected biological results, for example a parentage test rules out a ‘parent’ donor, the client may want to receive counselling. The Panel Member should refer the client to services that provide continuing counselling and support.

**Note:** A sensitive approach and background knowledge of cultural and/or religious issues relating to those being counselled is required. Consider possible implications of counselling and how to manage them.

The Departure Health Check (DHC)

The Department offers Departure Health Checks to Refugee and Special Humanitarian Programme (RSHP) visa holders who are outside Australia. This must be conducted within three days of the client’s intended departure for Australia.

The purpose of DHC is to:

- ensure that RSHP clients are fit to travel
- ensure that clients have not developed any communicable diseases since undertaking their immigration medical examination
- provide vaccinations and de-worming treatment if required
- facilitate medical care/support and settlement needs on arrival in Australia.

As a Panel Member, you may be asked to conduct DHCs for clients referred by the Department. In the event that this is requested, the Department will provide you with detailed instructions and advice on completing the DHC.

Protection visa applicants (in Australia only)

Panel Members in Australia should refer to the *Procedural Advice Manual 3: Sch4/4005-4007* for information on requirements for Protection Visa applicants.
Part B: The Medical Examination (eMedical Requirement 501)

This part of the instructions provides advice for Panel Physicians on how to complete the medical aspects of an immigration medical examination (IME). Advice for Panel Radiologists on how to complete X-ray examinations is provided at Part C.

Immigration medical examinations are completed using eMedical (requirement 501), or only where eMedical is not set up, by completing the paper Form 26. Clients should be advised when making an appointment that they should bring along all previous medical records, any visual aids (such as glasses or contact lenses), and any medication, as well as advising fees, any access difficulties and noting that a full physical examination will be undertaken requiring them to undress to underwear. Women should be advised not to attend during menstruation as this may affect the urine test result.

It is worth remembering that there are specific challenges for the Panel Physician conducting an IME. Unlike a standard medical consultation, clients may be disinclined to be fully transparent with their medical history, and may attempt to conceal significant clinical findings, if they believe, rightly or wrongly, that this may result in delays or obstacles to them obtaining a visa.

Special care is required in order to ensure that all relevant findings are identified and recorded accurately.

17 Medical History

Panel Physicians must review client health declarations in the Medical History section and take note of any abnormalities. The Panel Physician should bear in mind that third parties may have completed the health declaration and they must ensure that the client understands the questions and they must reconfirm the answers with the client. It is not acceptable to delegate history taking to paramedical staff (such as nursing staff). Remember that the client's declaration is a legal document.

If clients are not able to communicate for language reasons, arrangements must be made for an accredited interpreter. Family members may not be impartial.

The medical history questions are designed to assist the Panel Physician to assess aspects of the client’s health of particular relevance and importance to the Australian Government's health requirements. The questions do not replace the need for Panel Physicians to obtain comprehensive histories themselves. If there is no medical history declared, the Panel Physician must verify this with the client. Panel Physicians should not merely repeat the questions but explore much more fully the applicant's understanding and honesty through asking in a variety of ways.

Panel Physicians should specifically review comments regarding previous hospitalisations, institutionalisation for physical or mental conditions, or any condition resulting in a substantial change from normal state of well-being.

Social history such as information about educational achievements, work or school history, interests or hobbies, receipt of government benefits such as pensions, and current living arrangements are all useful in assisting Panel Physicians to identify possible significant conditions, such as physical or intellectual impairment.

Panel Members must ask applicants about TB symptoms and TB history including family members, mental health conditions, behaviours consistent with substance abuse, and current medication. If significant conditions are identified, they must be recorded.

Panel Physicians should engage with children directly and not simply rely on advice provided by parents. If a child attends with a parent or guardian who is not familiar with details of the child’s history, this should be recorded. School reports can also be a useful adjunct in assessment of children.

Previous medical records should be reviewed and attached to the 501 examination if relevant.
18 Physical Examination

As noted above, clients may attempt to conceal significant findings. They must be asked to remove sufficient clothing for a full and appropriate medical examination. This means that all clothing including shoes and socks with the exception of underwear must be removed so that the skin is bared. Modesty can be maintained by using a gown and drop (cover) sheet.

Appendix E provides a diagram that you may wish to display in your clinic waiting room, change and/or examination room.

A chaperone should be offered routinely (see section on chaperones in these Instructions).

The examination must include an assessment of general appearance, a full head to toe examination of all major organ systems which should incorporate cardiovascular, respiratory, gastrointestinal, endocrinological, neurological, musculoskeletal and haematological, (including head and neck, chest, abdomen, back and extremities) and a mental health assessment.

19 Height, Weight and Head Circumference

The examinee’s height and weight should be determined accurately (in street clothes and without shoes) and recorded in centimetres and kilograms respectively. eMedical automatically generates BMI.

In infants and children, growth parameters (height, weight and, in those under two years of age, head circumference) should be assessed against standardised charts for the appropriate population.

Children who are significantly underweight for age (under 3rd centile) may require referral to a specialist paediatrician for assessment. If developmental delay is suspected, the assessment should include appropriate psychological testing, and developmental age/IQ estimation.

Growth charts supplied courtesy of the respective agencies can be accessed through the following links:

- Centre for Adoption Medicine: www.adoptmed.org/topics/growth-charts.html (this includes links to country specific growth charts)
- CDC: www.cdc.gov/growthcharts/charts.htm

20 Eyes

Clinical examination of the eye and measurement of visual acuity must be conducted. The distance visual acuity of both eyes can be done together but must be tested separately if poor vision is identified or fundal examination abnormal. This should be undertaken with corrective lenses if they are usually worn, using a Snellen or similar test. The results must be recorded in metric fractions. For illiterate examinees and children, E charts or picture charts can be used.

If defective vision is found, record the cause (if known), for example: myopia, hypermetropia or astigmatism. If a client has not brought glasses, pinhole testing for acuity should be used. In children too young to read the test charts or to use an E-chart or a picture chart, a comment must be made on whether the vision appears normal.

Fundoscopy is required routinely and should be performed by the Panel Physician. Dilation of pupil and referral to specialist ophthalmologist is not indicated for routine fundoscopy.

Refer to Appendix F for required investigations and grading of Visual Impairment. Note that eMedical will automatically grade as ‘B’ if corrected visual acuity is less than or equal to 6/24 in the better eye.

21 Urinalysis

Every client who is five years of age or older must have their urine tested for the presence of albumin, sugar and blood. Children younger than five years of age should be tested if clinically indicated, for example when there is a history of kidney disease.
Urine should be passed at the time and place of the examination in a secure collection area in the Panel Physician’s rooms, not in the laboratory. To maintain the integrity of the test, the applicant must be escorted and supervised during access to the toilet. Ideally, there should be no hand basin inside the toilet cubicle to prevent dilution of the specimen with tap water or blue dye in the toilet bowl should be used. Personal items such as handbags are not allowed inside the toilet. Minimise the applicants’ clothing by providing gowns or ensuring pockets are empty.

Panel Physicians should immediately check for ‘freshness’ of the specimen (37 Degrees Celsius, bubbles, condensation on the jar). Dipstick is required as the initial urine screening test and should be conducted prior to the medical examination or during the consultation so that the Panel Physician has immediate access to the results.

Although eMedical allows microscopy to be selected for the initial urine screen, dipstick urinalysis should be used for Australian visa applicants. However, if the initial urinalysis test and the repeat are both abnormal, additional tests will be required as outlined below. Specimens requiring referral to a laboratory for further testing must be labelled with a de-identified and coded label before transporting.

Recording urinalysis results

Dipstick results should be recorded as negative or quantitatively, as trace, 1+, 2+, 3+ or abnormal. Do not record additional dipstick results such as white cells or ketones.

Repeat urinalysis and microscopy

Abnormalities (trace or more of protein, blood or glucose) will generate a repeat urinalysis. This should be done immediately, before the client leaves the premises. If protein, blood or glucose is present in the repeat specimen, proceed as follows:

Proteinuria

Proteinuria can be a sign of renal impairment. Serum creatinine is required in cases where the repeat dipstick urinalysis shows ‘one plus’ or more of protein. If not routinely provided by the laboratory, eGFR should be calculated and included with the result. A sample tool which can be used to calculate eGFR is:


If creatinine > 2.0 mg/dL (177 µmol/L), refer the client to a nephrologist for investigation.

If there is concomitant diabetes, an endocrinologist may be a suitable alternative to a nephrologist for obtaining specialist review.

Haematuria

If the repeat urinalysis shows 1+ or more of blood, then eMedical will generate urine microscopy. This should include red cell count and morphology. For paper cases, obtain and attach results of microscopy and culture, and/or serum creatinine (including eGFR), as clinically indicated.

If, despite counselling above, women are menstruating at the time of the examination, the repeat test should be postponed. If not postponed, note should be made that the sample was collected during menstruation.

In young people, isolated haematuria (that is, in the absence of proteinuria) is usually insignificant from a health requirement perspective. If microscopy shows less than or equal to 10 red cells per high power field, and there are no other abnormalities, the case can be A graded.

Malignant lesions may need to be excluded and these are more common in those over the age of 50. In that group, if repeat urinalysis is positive and microscopy shows more than 10 red blood cells per high power field, consider further investigation.

Haematuria in conjunction with proteinuria is more likely to be indicative of renal disease.

All cases where haematuria and proteinuria are both present, regardless of the number of red cells, must be ‘B’ graded.
Glycosuria

Isolated glycosuria in known diabetics is not significant from an immigration health requirement perspective and can be A-graded if no end-organ damage is suspected. There is no indication to order glycosylated haemoglobin (HbA1C) in these clients.

If the client is not a known diabetic, referral to their own treating physician for follow up is indicated as a duty of care issue. Further investigation or referral to a specialist is only required for the purposes of the IME if end-organ damage is suspected.

Isolated glycosuria (that is, if all other parameters are normal), with no clinical evidence of end-organ damage, can be A graded, regardless of whether or not the client is known to be diabetic.

If end-organ damage is suspected in a diabetic this should be ‘B’ graded.

22 Cardiovascular Disease

Examination of the cardiovascular system should include palpation of pulses, auscultation for carotid bruits, blood pressure, palpation of apex beat and auscultation at apex, left sternal edge and both second intercostal spaces at a minimum.

Hypertension

If hypertension is detected, further investigation is needed only if:

- end-organ complications, such as ischaemic heart disease, renal impairment, cerebrovascular or peripheral vascular disease, or retinopathy are present
- the repeat BP is $>140$ mmHg systolic and/or $>90$ mmHg diastolic.

If the client’s repeat BP exceeds 160/100, then serum creatinine (examination 704) is required, even in the absence of proteinuria. Referral to a specialist (cardiologist or nephrologist) is indicated if the BP is unstable and/or end-organ disease is present.

eMedical will automatically generate a request for serum creatinine if required.

Specialist cardiologist review is unlikely to be indicated for those who are known to be hypertensive. Reports from the client’s own treating doctor can be provided if available. Routine electrocardiograms (ECG or EKG) are not required for the purposes of the health assessment.

A specialist cardiologist report is likely to be indicated in those whose hypertension was detected at the time of the IME, especially in the presence of:

- proteinuria
- clinically evident signs of vascular disease (such as cerebrovascular, retinopathy, peripheral vascular disease, cardiac murmurs or cardiomegaly).

These cases should be B graded.

Other cardiac conditions (including cardiac murmurs and ischaemic heart disease)

Stable, asymptomatic and uncomplicated cardiac conditions with a clear diagnosis, which are considered unlikely to impact on the client’s stay in Australia, require no further action.

Unstable or progressive symptomatic, complicated, or likely to impact on the client’s health during the proposed stay require referral to a cardiologist or appropriate. The specialist’s assessment should address history, diagnosis, clinical examination findings, treatment needs and expected prognosis.

Appendix F provides additional advice, including whether to grade ‘A’ or ‘B’. 
23 Respiratory System

A thorough respiratory examination must be performed, including chest auscultation of the bare chest in all cases.

Tuberculosis (TB)

The immigration medical examination places particular emphasis on the detection and management of TB.

Please refer to Part D Technical Instructions for Tuberculosis Screening and Treatment for complete technical advice and specific instructions for Panel Physicians.

Other respiratory conditions

Clients with examination findings or X-ray changes indicative of other respiratory disorders, for example malignancies, emphysema and bronchiectasis, where clinically indicated may be referred for a specialist assessment. Additional investigations, which may include CT scan, lung function testing or biopsy, are discouraged unless there are clear clinical indications, or for diagnostic purposes. Submit specialist report and ‘B’ grade the case.

If asymptomatic or not clinically warranted, submit the case with a ‘B’ grade. An assessment will be made and further specialist referrals requested where required.

24 Nervous System (including sequelae of stroke or cerebral palsy)

Panel Physicians should be aware of medical conditions which are risk factors for neurological disease (for example, cardiovascular disease or diabetes mellitus) and take particular care in completing a comprehensive neurological examination in those clients.

A comprehensive examination is required incorporating at a minimum a basic cranial nerve examination, tests for power, sensation and reflexes, as well as gait and balance. All neurological abnormalities should be recorded. Medication used to treat conditions such as multiple sclerosis must be noted.

It is particularly important to assess the effect of neurological (and musculoskeletal disorders) on a client’s ability to carry out daily tasks and capacity to work.

A detailed assessment of functional ability must be provided and any work restrictions or significant loss of time from work must be documented. Specialist referral may be necessary to reach a formal diagnosis and prognosis or the applicant may have reports from their own doctor. Choice of specialist will be determined by availability but may include a neurologist, rehabilitation physician, occupational therapist, occupational health physician or orthopaedic surgeon.

Activities of Daily Living (903) request will be generated in response to an abnormal nervous system, mental or cognitive state, or a positive response to the question about whether there are any physical or mental conditions which might affect work capacity.

25 Brain and Cognition (mental and cognitive status and intellectual ability)

Mental health conditions can be particularly difficult to identify, especially in the absence of a complete history. Referral for psychiatric assessment and determination of prognosis, treatment needed, including hospital admissions, work history, ability to carry out activities of daily living, and social history is necessary when there is a recent history, current clinical evidence or symptoms of the following:

- schizophrenia
- bipolar or depressive affective psychosis
- personality disorder
- paranoid disorder
- autism (paediatric review may be more appropriate)
- chronic alcohol abuse
- drug dependence or substance abuse
- eating disorders
- chronic neurosis (for example: chronic anxiety or depression, obsessive-compulsive disorder, phobias).

**Dementia**

If abnormal mental or cognitive state is suspected, Mini Mental State Examination (MMSE) and Activities of Daily Living (ADL) are required.

MMSE and ADL forms are available in eMedical (examinations 901 and 903, respectively). The ADL will be generated by eMedical if mental or cognitive state is marked abnormal. ADL assessment is provided in Appendix H.

The MMSE is one of many screening tools that can be used. If it suggests a problem, a psychiatrist’s or geriatrician’s opinion should usually be sought. The tool should be adapted, as appropriate, linguistically and culturally. The test questions should be performed in the client’s own language or with the assistance of a professional interpreter. If a language barrier to assessment is present, this should be recorded. These cases must be ‘B’ graded (eMedical will generally auto- ‘B’ grade). The MMSE tool is available in eMedical (examination 901) and can be added as necessary.

**Intellectual ability**

Referral for psychological or psychiatric assessment, as appropriate, is needed if there is clinical evidence of an intellectual disability whether this is borderline, mild, moderate or severe.

It is important for the Panel Physician to make comment on the following, and, if uncertain, to refer to an appropriate specialist, such as a paediatrician, clinical psychologist, or psychiatrist:

- diagnosis and any specific medical needs
- behaviour
- need for long-term supported care, and/or special educational needs (in children)
- level of independence and need for assistance or institutional care
- occupational history and employment capacity.

### 26 Early Childhood Development

A developmental assessment of infants and children, including that of major milestones, is part of a general physical examination and should always be undertaken in children under five years of age.

Panel Physicians should avoid relying solely on parents/guardians as interpreters when conducting developmental assessments of children as this may not result in an impartial assessment. Note also that children who have been deprived of adequate stimuli, such as those who have been institutionalised (for example, are being adopted), some delay in achieving milestones is not unusual.

The following represent critically delayed milestones:

<table>
<thead>
<tr>
<th>Delayed Milestone</th>
<th>Normal Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>cannot hold head up unsupported at eight or more months of age</td>
<td>(normal - two months)</td>
</tr>
<tr>
<td>Cannot sit unsupported at nine months</td>
<td>Eight months</td>
</tr>
</tbody>
</table>
### Delayed Milestone vs. Normal Milestone

<table>
<thead>
<tr>
<th>Delayed Milestone</th>
<th>Normal Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannot walk at 18 months</td>
<td>13 months</td>
</tr>
<tr>
<td>No words by 18 months</td>
<td>15 months</td>
</tr>
<tr>
<td>No two to three-word phrases by 24 months and 36 months respectively</td>
<td>21 months and 36 months</td>
</tr>
<tr>
<td>Moro reflex persisting at six or more months of age</td>
<td></td>
</tr>
</tbody>
</table>

Non-symmetrical findings on examination and significant hypotonia or hypertonia are abnormal at any age.

If developmental milestones are noted to be abnormal, a chart of early childhood development must be completed (examination 904 in eMedical). Appendix G provides additional guidelines for those submitting paper cases. Paediatric referral (examination 124) can be considered.

If developmental milestones are abnormal, a paediatrician’s report should be obtained and attached (Examination 124 – Paediatric Report). A developmental psychologist report can also be useful. If the child is known to have developmental delay, then a report from their own paediatrician may be valuable along with school reports in older children.

### 27 Gastrointestinal System

Examination of the gastrointestinal system includes examination of the abdomen with the skin bared. Abdominal masses, hepatosplenomegaly, and ileostomy or colostomy sites, inflammatory bowel disorders, and unexplained recent weight loss should be documented. Investigation is likely to be needed and may include ultrasound scan, hepatitis serology testing, and/or a recent gastroenterologist or specialist report.

Rectal examination is never required for the purposes of an IME.

History of, and operative scars from, commonly performed surgery, such as appendectomy, hernia repairs or cholecystectomy do **not** need to be recorded if the condition is uncomplicated and/or has resolved. Further guidance is available in Appendix I.

### 28 Musculoskeletal System (including mobility)

Joints and spine should be fully examined and taking into consideration the age of the applicant, Panel Physicians must comment on any abnormalities detected as follows:

- **Children**
  - likely need for further operations and specialist care
  - effect on attendance at school/future employment
  - need for continuing care.
- **Working age applicants**
  - the effect on current and future employment.
- **Elderly applicants**
  - the capacity to carry out activities of daily living and live independently.

Activities of Daily Living (ADL, or examination 903, Appendix H) is required if there are musculoskeletal conditions that interfere with activities of daily living.

### 29 Skin and Lymph Nodes (including genitalia)

The presence of operative scars must be correlated with the applicant’s history. It is **not** necessary to record scars associated with routine surgical procedures, such as hernia repair or appendectomy, hysterectomy or Caesarean section, if the procedure was uncomplicated and/or the condition resolved. Appendix I provides further guidance on this issue.
Skin conditions which are stable and do not affect ability to function, such as acne or atopic conditions (eczema or dermatitis) do not need to be recorded in eMedical.

Cervical, axillary and inguinal nodes should be palpated. Enlargement of lymph nodes should be described fully and correlated with regional conditions. If there is clinical concern, referral to a haematologist, oncologist or infectious disease specialist for assessment and a report is required. Extra-pulmonary TB should be part of the differential diagnosis.

In male and female clients, examination of the external genitalia is not required unless clinical evidence is presented to indicate a condition requiring notification.

Gynaecological examination (vaginal or pelvic examination) is never indicated in the context of the immigration medical examination. If there has been a history or clinical suspicion of gynaecological malignancy, refer the applicant to a gynaecologist.

30 Evidence of Drug-Taking
Details should be recorded of any indications of possible drug abuse, such as puncture marks, phlebitis, abnormal pupil size, and mental state. If alcohol or other drug abuse is suspected, details of diagnosis, prognosis, work history and ability to work in the future should be included. A referral to a relevant specialist, such as a psychiatrist or general physician, may be indicated. Hepatitis B, C and HIV testing is indicated if there is a history of intravenous drug use. These tests should be added manually and, if positive, the cases should be ‘B’ graded.

31 Breast Examination
Breast examination is required routinely for women 40 years of age and older and/or if there are clinical indications in younger women. Breast examination is not routinely required in women under the age of 40.

Clinical indications for examination, regardless of age, include a history of breast cancer or suspicious breast lumps (for example, not benign disease), or if axillary nodes are palpated. If breast examination is indicated, applicants should be asked to remove brassieres only for that purpose. Examinations must be conducted with sensitivity and, in the case of a male Panel Physician, in the presence of a chaperone. If a client is unduly anxious or upset about a breast examination, do not insist. Instead, note the clinical indication(s), and that the applicant declined examination.

If there is suspicion of malignant disease, then the applicant should be referred for specialist review. Further investigations such as mammography, ultrasound scan and/or biopsy can be considered. Benign breast lesions such as fibroadenoma, or fibrocystic disease do not need to be recorded in eMedical and can be ‘A’ graded.

32 Endocrine System
Clients with isolated glycosuria, or who are known to have diabetes mellitus, should be graded as per Appendix F. If there is no evidence of end-organ complications, no further investigation is needed. However, if complications are known or suspected, referral to a physician is required for:

• treatment
• assessment of end-organ damage
• estimation of prognosis.

Signs of end-organ disease include:

• dipstick proteinuria
• reduced visual acuity or retinopathy
• hypertension
• angina pectoris
• peripheral sensory loss and foot ulcers
• vascular bruits
• weak peripheral pulses
• focal neurological signs.

Examination of the endocrine system should include thyroid examination. Clients known to have benign thyroid disease do not need additional investigations such as thyroid function tests and should be ‘A’ graded. If thyroid disease is detected on examination then malignancy should be excluded.

33 Ear, Nose, Throat and Mouth

Panel Physicians should provide comment if an applicant has any significant abnormalities present, such as cleft palate or malignant lesions. Minor conditions such as dental caries, uncomplicated ear infections, or nasal polyps do not need to be recorded.

34 Hearing

If a client can hear (not lip-read) the Panel Physician’s questions without difficulty, during the examination and can conduct a conversation in response to the Panel Physician, then the hearing should be considered satisfactory. If there is a hearing impairment, the communication skills that are used by the client need to be recorded. That is, it should be noted if the client uses lip-reading, signing, reading or writing.

If severe hearing impairment is detected, especially in children and young adults, formal audiological assessment and/or a report from a specialist is required detailing the diagnosis and further management requirements, and the applicant’s abilities and special needs (such as supported education, speech pathology or surgery, including cochlear implantation).

35 Conditions Preventing Attendance at Mainstream School, Full Employment or Living Independently

Consider any condition or finding that has current or likely future impact, on the client’s capacity for independent living and/or employment, and provide full details. The ADL assessment (903 Appendix H) needs to be completed for any client where there is concern about their ability to carry out the activities of daily living, including the frail elderly.

Where there is concern about capacity for full employment, full details of the client’s work history must be provided for the previous five years as well as details of any anticipated employment restrictions and any pensions currently received. Full details must be provided of any required rehabilitation services currently being provided to the client, or which will be needed in the future.

36 Human Immunodeficiency Virus (HIV) Testing

<table>
<thead>
<tr>
<th>Type of Client</th>
<th>Test for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent visa applicants 15 years of age and older</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-migrating relatives of Permanent visa applicants, aged 15 years or older</td>
<td>Yes</td>
</tr>
<tr>
<td>Children who have been, or are to be, adopted by Australian residents</td>
<td>Yes</td>
</tr>
<tr>
<td>Unaccompanied Minor Refugee Children</td>
<td>Yes</td>
</tr>
<tr>
<td>Children younger than 15 years of age with clinical suspicion for HIV infection, a history of blood transfusions or haemophilia, or if the mother is HIV-seropositive.</td>
<td>Yes</td>
</tr>
<tr>
<td>Temporary Entry Applicants with clinical signs of AIDS</td>
<td>Yes</td>
</tr>
<tr>
<td>All applicants who intend to work as, or study to be a physician, nurse, ambulance paramedic or dentist*</td>
<td>Yes</td>
</tr>
<tr>
<td>Persons known or found to be infected with Hepatitis C</td>
<td>Yes</td>
</tr>
<tr>
<td>Persons where there is evidence of previous or current intravenous drug use</td>
<td>Yes</td>
</tr>
<tr>
<td>Persons where active TB is diagnosed</td>
<td>Yes</td>
</tr>
</tbody>
</table>
* Other allied health professionals including physiotherapists, occupational and speech therapists, laboratory technicians and veterinarians, do not routinely need HIV, hep B or hep C testing.

The visa case officer will generate testing requirements for HIV, based on visa class and intended occupation in Australia. A summary is provided in the table above.

Venepuncture should be done onsite at the Panel clinic once the applicant’s identity has been confirmed.

**Identity of examinees**

The identity of clients must be confirmed to prevent substitution. Specimens should, ideally, **not** be labelled with the client’s name due to privacy and security reasons. The specimen should be labelled with bar-coded identifiers. The Panel Member should retain the register connecting the coding to the applicant’s name. When the pathology result is received the Panel Member should write the client’s name on the result before submitting to the Department.

**Pre-test counselling**

Before a HIV test is performed, pre-test counselling should be provided to the client by the Panel Physician. In some circumstances, it may be appropriate for suitably trained health care workers to provide this counselling.

Regardless of who provides basic pre-test counselling, the Panel Physician should, during the medical consultation, also explain:

- that the HIV-test is required as a part of the immigration medical examination
- the nature of HIV infection and the acquired immunodeficiency syndrome
- that the results of the test will be provided to Australian Government agencies, as well as health providers in Australia if a visa is granted
- the concept of a false positive screening test.

**Acceptable screening tests for HIV**

There are four broad categories of HIV tests: simple/rapid anti-HIV tests, Enzyme ImmunoAssays (EIAs), immunoblot tests and nucleic-acid tests.

First-line HIV screening should ideally be performed with a fourth generation EIA based kit. Third generation kits are acceptable if fourth generation kits cannot be accessed. Machine-based ELISA assays are acceptable as first-line screen.

Any initial reactive or indeterminate screening test should be rechecked with an alternate HIV test using the same blood sample. If still reactive or indeterminate then formal confirmatory testing is required.

**Confirmatory and supplementary tests**

- **Screening test negative** - no further action is needed.
- **Screening test indeterminate** - proceed to confirmatory testing with immunoblot. If this is not available, retesting with a different EIA method to the original test is advised.
- **Screening test reactive** - a second supplemental test to clarify the status of the sample should be performed with a confirmatory immunoblot assay. If these are not available, retesting with two alternative kits is advised.

**Positive results and post-test counselling**

If a client is found to be HIV positive, based on reactive initial and/or confirmatory tests in a person not already known to be infected, the Panel Physician should arrange for a second consultation and then
refer the client to their own physician or a suitable specialist for follow-up counselling and management. The Panel Physician must record that the client has been counselled.

The following points should be covered in post-test counselling where there is a positive result:

- implications and possible prognosis
- ways of protecting others from infection with HIV
- ways in which the applicant can minimise opportunistic infections
- referral for continuing counselling and support
- referral for early medical intervention.

If asked about the effect a positive result may have on an applicant’s likelihood of meeting the health requirement, the Panel Member should state that this is a matter for the Department to consider. Any further inquiries by applicants should be referred to their case officer.

If the Panel Physician is unsuccessful in contacting the client, this should be recorded on the client’s case and Immigration Health should be notified.

### 37 Hepatitis B and C

Where indicated, clients in the following categories must undergo a blood test for the presence of Hepatitis B surface antigen and Hepatitis C antibody.

<table>
<thead>
<tr>
<th>Type of applicant</th>
<th>Hepatitis B Surface Antigen Test</th>
<th>Hepatitis C Antibody Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women intending to deliver in Australia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Children for adoption</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children who have been, or are to be, adopted by Australian residents</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Unaccompanied minor refugee children</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>High risk applicants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- permanent applicants with a history of hepatitis, jaundice or blood transfusions</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>- people showing clinical evidence of Hepatitis B or Hepatitis C infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All visa applicants intending to work as or study to be a physician, nurse, ambulance paramedic or dentist</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Persons where there is evidence of previous or current intravenous drug use</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Allied health workers such as occupational therapists, physiotherapists or social workers do **not** need serological testing for Hepatitis B or Hepatitis C.

_For applicants_ found to be Hepatitis B or C positive testing for the alternate strain is needed. If a client is found to be Hepatitis C positive, then HIV testing is also needed.

Liver function tests are required if either Hepatitis B sAg or Hepatitis C Ab tests are positive. Ultrasound scans and gastroenterologist reports are needed only if liver function is abnormal.

All members of a Hepatitis B carrier’s family, whose own Hepatitis B surface antigen tests are negative, should be advised of the desirability of Hepatitis B vaccination.

Persons with tattoos do **not** need additional serological testing for Hepatitis B, Hepatitis C or HIV. If no other medical findings are present, persons with tattoos should be graded ‘A’.
38  **Venereal Diseases’ Reference Laboratory (VDRL) test**

A Venereal Diseases’ Reference Laboratory (VDRL), Rapid Plasma Reagin (RPR) or equivalent test for syphilis is required **only** for refugee applicants aged 15 years of age and older.

If the screening test is positive, Panel Physicians should do a Fluorescent Treponemal Antibody (FTA) or Treponema Pallidum Particle Agglutination Assay (TPPA) test. If the result of the specific test is also positive, treatment should be provided and noted on the medical. Unless treatment has failed or follow up is needed in Australia, the case can be graded ‘A’.

39  **Grading ‘A’ or ‘B’**

The ‘A’/‘B’ grading system is designed to allow rapid identification of clients who may have significant conditions or findings. eMedical assists by automatically grading ‘B’ in some cases, where the client’s history or examination has identified certain findings.

Panel Physicians must complete this section in accordance with the following guidelines:

- ‘A’ Grade: cases without significant conditions or findings
- ‘B’ Grade: cases with significant conditions or findings.

Panel Physicians take responsibility for the 501 requirement at the time of grading even if other staff have performed data entry for some aspects of the case. Panel Physicians should ensure that they have reviewed the chest X-ray and/or serology findings, if applicable, before grading and submitting the health case. Where there is a 501 and 502 requirement, the 502 examination must be completed by the Panel Radiologist before the health case can be submitted by the Panel Physician.

Where the Panel Physician disagrees with the 502 grading, this should be discussed with the Panel Radiologist. The 501 grading should reflect the 502 examination that the Panel Physician decides.

When deciding if to grade ‘A’ or ‘B’, the most important decision is whether or not a condition or finding is significant.

**When is a condition or finding significant?**

A significant condition or finding has current or foreseeable future implications for the client’s health and/or functional capacity. Any condition is considered significant if any of the following applies:

- represents a potential public health risk
- is likely to need substantial medical treatment either now or in the future
- negatively impacts the applicant’s capacity for independent living
- negatively impacts the applicant’s intended activity in Australia
- presents a barrier to safe travel.

Important examples of significant conditions are TB, HIV, organ failure, malignancies, diabetes with end-organ involvement, psychiatric disorders, including dementia, and intellectual or physical disability. If in doubt, contact Immigration Health for clarification.

**Condition or findings that are not significant**

A condition or finding is not significant if it does not have current or future implications for the client’s health. Minor past surgery, incidental anatomical variations, trivial medical conditions, and previous illnesses with no ongoing implications are not significant. Routine medications taken for uncomplicated disorders of mild severity, such as salbutamol for mild asthma, are not significant.

**‘A’ Grades**

Where no significant conditions are found, mark the relevant field as ‘normal’ and enter any comments into the general supporting comments box in eMedical or on the last page, if using paper forms.
The case will be ‘A’ graded when all the criteria below are met:

- No significant conditions or findings are identified.
- Physical findings are “not significant from a migration perspective” including a blood pressure at or below the recommended levels, no significant cardiac murmur, no significant urinary abnormalities and a visual acuity, corrected if necessary, of no worse than 6/18 in the better eye.
- No medical or surgical condition is present which would need further investigation or treatment currently or in the foreseeable future (10 years).
- The examinee is independent with the activities of daily living without family or other assistance, and nursing or institutional care is not needed now or in the foreseeable future.

Where any condition is identified as stable and of no clinical significance, ‘A’ is the appropriate grade.

‘B’ Grades

‘B’ grades should always be recorded when any of the conditions in this section are not met, when conditions or findings are present or if the Panel Physician has reservations about a client’s fitness.

‘B’ grade does not mean that an applicant will not meet the health requirement and does not mean that the client will not be granted a visa. The grading is simply a means to improve efficiency of processing and identify cases which require further consideration by a MOC.

Further information about specific medical conditions can be found in Appendix F and I. For details of situations where eMedical automatically grades ‘B’, see Appendix F.

40 Additional Health Examinations and Deferral Requests

Some health examinations are auto-generated by eMedical. These are designed to expedite specialist referral or laboratory testing and avoid delays which may be clinically inappropriate. An example is the 603 (chest clinic) examination which is auto-generated if the radiologist records strong suspicion of active TB.

Deferral requests are generated by Medical Officers of the Commonwealth (MOCs). When this occurs, clients requiring further investigations or specialist reports will be provided with a deferral letter from the Department asking them to return to the Panel Physician.

For paper based clinics, the client must return to the clinic where the original immigration medical examination was conducted.

For eMedical cases, the client is advised that they should return to the original panel clinic, as this allows continuity of care, however eMedical will allow them to attend another panel clinic if they choose to do so. Usually this comes about if the client has relocated.

Clients are generally allowed a maximum of 28 days to complete additional health examinations. TB investigation will take at least two months and should be implemented immediately (See Part D). Clients who require additional health testing but fail to comply should be reminded of the outstanding requirement. If they wish to withdraw from the process, the Panel Member should submit the examination by finalising as incomplete. If there is no further contact from the client and no reports are received within a reasonable time frame the Panel Member should submit the examination by finalising as incomplete.

For cases where clients require TB investigation, the time frame will be significantly longer. All clients needing sputum testing must have this done within one week of receiving notification and this should be arranged by the panel clinic as soon they are aware.

Panel Members must actively monitor clients who require TB investigation and/or treatment and keep case records. Information (sputum test results, chest clinic reports and additional chest X-ray films) should be uploaded and submitted when all examinations are completed. Clients needing TB treatment have additional requirements which are outlined in Part D of these instructions.
Part C: Completing an Immigration X-ray Examination (502)

This part of the Instructions provides advice for Panel Radiologists on how to complete an immigration chest X-ray examination. Advice for Panel Physicians on how to complete medical examinations is provided in Part B.

Chest X-ray examinations are completed in eMedical by uploading the compressed X-ray image in DICOM format and the completed radiologist report or where eMedical is not available, by attaching the analogue chest X-ray image to the using the paper Form 160.

41 Taking the Chest X-ray

Radiographic technique

Chest X-rays should be taken in the posteroanterior (PA) projection to reduce cardiac magnification.

Panel Radiologists should ensure:

- penetration is such that the first four vertebral bodies (T1-T4) and the ribs are visible, while the rest of the vertebrae should be just visible through the heart shadow
- chest X-rays are taken in full inspiration, evidenced by the diaphragm lowered to the level of the 10th or 11th rib posteriorly
- that the client is positioned perpendicular to the X-ray beam so that the medial ends of the clavicles are equidistant from the spinous processes of the thoracic vertebrae
- scapulae are clear of the lung fields and both apices and costophrenic angles visible
- images are free from artefacts (for example, hair and jewellery) and technical artefacts.

Special views

An apical lordotic view should be done for suspicious opacities over ribs, clavicles or other structures and a lateral decubitus view if pleural effusion is suspected if there is costophrenic angle blunting. Ultrasound imaging can also be considered to exclude effusion.

CT scans should not be routinely performed unless clearly clinically indicated (for instance where malignancy is suspected) or if requested by a MOC as part of the deferral process.

Radiation safety

Radiation safety should be maximised by:

- routine use of lead shielding for all clients
- storing lead shields appropriately -not folded as this may crack the lead and allow radiation leakage
- testing the integrity of lead shields annually by exposing them in front of an X-ray plate
- selection of correct film size
- X-ray beam collimation (narrowing of the beam so that only the target area is exposed)
- ensuring correct radiography procedures and machine settings are used to minimise repeat exposures requested for technical reasons
- avoiding unnecessary additional X-rays or scans, in particular Computerised Tomography (CT) scans minimising radiographer exposure
• ensuring all staff in the radiography working area wear dosimeters (radiation badges).

**X-ray image identification**

The X-ray image must bear the:

- date of the examination
- HAP ID or Passport Number
- full name of the examinee in English
- examinee’s date of birth
- name of the X-ray clinic
- anatomical side markers.

eMedical enabled clinics should refer to the agreed naming conventions for mandatory attachments in *Module 8 of the eMedical User Guide*, found in eMedical, in relation to chest X-ray images.

**Film size for paper medicals**

For paper medicals, full-size 14” x 17” (35cm x 42cm approximately) PA films should be submitted for routine X-ray examinations of the chest. If this is unavailable, contact Immigration Health. Image files on CDs are not accepted in lieu of hardcopy prints.

**X-ray images for eMedical**

eMedical images should be submitted as DICOM files with a file size of approximately 350–500kb. The type of X-ray image (for example, PA view, lateral view) should be recorded in the ‘details’ section at the time of attachment.

**Women**

Women of reproductive age may be unknowingly pregnant at the time of the X-ray and must be provided with protective lead shielding in preparation for X-ray exposure. CXRs are the routine method to screen female applicants, who could be pregnant, for TB. Panel Physicians must ask female applicants of child-bearing age about pregnancy and the last menstrual period.

Almost all imaging tests expose the foetus to such low levels of radiation that they are not a cause for concern. The International Commission on Radiological Protection (ICRP) has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation.

The ICRP has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation. If the pelvis or abdomen is not in the direct beam the foetal dose is usually <1 mGy. The typical foetal dose of a CXR is 0.001–0.01 mGy.

The radiologist responsible for the radiological examination should take all reasonable steps to advise the pregnant applicant of the potential risks of radiation exposure of the foetus. For pregnant patients, written informed consent is only recommended if the pelvis is in the direct beam and this consent is required prior to the radiological exam. If consent is not provided, the Panel Physician should provide the option of delaying the CXR and health clearance until after delivery.

Panel Radiologists have an ethical obligation to ensure pregnant applicants are adequately protected, using double wrap around abdominal and pelvic shielding when appropriate. Be vigilant in avoiding unnecessary radiation exposure. Panel Physicians must adhere to national guidelines where applicable.

If a female client prefers to wait until after pregnancy to have the X-ray, a pregnancy deferral can be generated in eMedical, which will allow Panel Members to delay submission until the X-ray has been completed and a deferral letter given to the client.
Where the client chooses to proceed with X-ray screening this should occur after completion of the first trimester, double lead wrap around abdominal and pelvic shielding should be provided. Please see Part A of these instructions provides further details of the Department's guidelines for pregnant women.

**Children**

Children aged from two to under 11 years of age from higher risk TB countries who are applying for permanent migration are required to undergo additional screening for TB to determine previous exposure to Mycobacterium tuberculosis (Tuberculin Skin Test or Interferon Gamma Release Assay). If this testing is positive, chest X-ray screening is required.

This should be a lateral view (health examination 510) as well as either an anteroposterior or a posteroanterior view (health examination 502).

Radiation exposure should be kept to a minimum. Film size should be adequate to include the chest only. Pelvic shielding and correct collimation should be used.

Children who are non-migrating family members of permanent visa applicants are exempt from undergoing routine chest X-ray if they are from a lower TB risk country or not suspected of having a significant medical condition otherwise. Such children are however required to still undergo a medical examination.

Panel Physicians who detect respiratory signs which may be indicative of a significant medical condition (such as pneumonia) can proceed to X-ray by adding a 502 and/or 510 examination in eMedical. Reasons for this should be clearly outlined by the Panel Physician in the medical examination section.

**Note:** In cases where Interferon Gamma Release Assay is refused by the parents or guardians of child clients, Panel Physicians should offer the Tuberculin Skin Test as an alternative is available. This also applies in the reverse, if available. Panel Physicians should not proceed to X-ray children in these instances. If both Gamma Release Assay and Tuberculin Skin Test are refused or the alternative test is not available, then the exam should be finalised as incomplete with a drop down comment added to indicate the client refused testing. Clients should not be offered chest X-ray (examination 502) as an alternative. Please contact Immigration Health in these situations.

**42 Film Examinations and Reporting**

The X-ray film is to be read by the Panel Radiologist. Look at the so-called ‘hidden’ areas:

- behind the heart
- apices
- costophrenic angles
- both hila
- paratracheal regions
- below the diaphragms.

Sometimes a nodule in the lower zones may be difficult to differentiate from a nipple shadow. Repeat X-ray with nipple markers to confirm. The extent and likely activity of any disease present should be described and any necessary further investigations recommended. Panel Radiologists should report all abnormalities and their interpretation and cause in the 502 comments field.

**Reporting tuberculosis findings**

Any findings consistent with new or old TB should be marked as ‘present’ on Question 6 (evidence of TB) and recorded in the text field that accompanies it. This will generate an automatic ‘B’ grade of the case once prepared for grading.

Findings that are highly suggestive of active TB should be marked accordingly on Question 7. Please note that this field should only be marked ‘yes’ when the findings are convincing for active disease (for
example, extensive infiltration or cavitation). This question should not be answered 'yes' simply if a suspicion of active disease exists.

Answering 'yes' to Question 7 will auto-generate requirement 603 when the case is prepared for grading. This requirement needs three items for completion, two document attachments and one X-ray image as follows:

- sputum results (including culture and DST where positive, when finalised)
- chest physician report
- repeat chest X-ray at least three months after the initial chest X-ray and when cultures are completed.

Panel Radiologists should immediately refer clients needing TB investigation to a Panel Physician. This is also the case for clinics using paper cases.

**Grading ‘A’ or ‘B’**

eMedical assists Panel Members by automatically grading cases as ‘B’ if significant fields are marked abnormal.

The following findings are not considered significant and should be ‘A’ graded, with all fields on the 502 requirement marked normal:

- aortic calcification
- apical capping (with smooth border)
- atelectasis
- azygous fissure/lobe or other accessory fissures
- breast implants
- cardiomegaly, mild (CTR <60) and otherwise normal X-ray
- dextrocardia or situs inversus
- nipple shadows
- pectus excavatum
- raised hemi-diaphragm
- rib abnormalities (for example: cervical ribs, previous rib fractures, bifid ribs)
- scoliosis.

Panel Radiologist should note such findings and they can be included as a general supporting comment next to the ‘A’ grading.

All other abnormalities, including evidence of current or previous infectious disease (including old TB), as well as significant extra-pulmonary abnormalities (such as evidence of heart disease) must be ‘B’ graded. In cases where evidence exists of previous significant surgery, then the Panel Radiologist should provide details and grade the case ‘B’.

Examples include:

- cardiac valve replacement
- sternal wiring
- vascular stents/shunts
- absent breast/s.

Cardiomegaly should only be reported if the cardio-thoracic ratio is greater than 60 per cent (0.60) on well inspired film and/or the cardiac shadow or vasculature indicates suspicion of heart disease (such as atrial enlargement, pericardial effusion or pulmonary hypertension).
43 Declaration by Examining Radiologists

In making the declaration, Panel Radiologists must ensure that:

- all information is accurate before submitting the case in eMedical
- for paper forms, date, place of examination and the Panel Radiologist’s name are clearly stated.

Panel Radiologists record the findings, grade the case, sign the declaration (if a paper case), then submit the case.

In submitting the case on eMedical, or signing the declaration for paper cases, the Panel Radiologist is acknowledging responsibility for the integrity and quality of the radiological examination process. Immigration Health routinely audits all radiological examinations and any evidence of failure to maintain integrity and quality of the examination will result in closer scrutiny of the Panel Radiologist and possible removal from the Panel.
Part D: Technical Instructions for Tuberculosis Screening and Treatment

44 Screening

The immigration medical examination places particular emphasis on the management of TB. This section provides technical advice and specific instructions to Panel Physicians on this topic. It outlines to physicians the importance of thorough history taking, comprehensive physical examination, interpretation of radiological findings, laboratory screening, and management of TB in the event of a diagnosis of either active or latent TB.

The diagnosis of TB in clients applying for visas has specific challenges. This is in part due to a perception from applicants that a diagnosis of TB will jeopardise the health clearance for the purposes of their visa. Clients may not provide an accurate history, they might attempt to send a substitute or in extreme circumstances seek investigation and treatment prior to attendance at the Panel Physician. These instructions attempt to provide some guidance to Panel Physicians to minimise the impact of these types of behaviours.

Funding the medical examination

Clients typically pay for their immigration medical examination and any subsequent tests needed to complete the medical examination. However, the World Health Organisation (WHO’s) position of TB management is that it is affordable. The End TB Strategy aims for zero per cent of people suffering catastrophic costs, and more targeted investigation of TB following primary screening. It is therefore recommended that Panel Physicians utilise a “global fee” system in which anticipated sputum testing and TB treatment costs are spread across the full applicant pool so that individual applicants are not charged separately for these costs. This encourages applicants needing sputum evaluation for TB to complete this evaluation and increases the chances that they will complete treatment (especially treatment coordinated by the Panel Physician programmes), thereby minimising the risk of further transmission and development of drug resistance. Panel Physicians will be monitored closely to ensure that all those requiring further investigation as outlined later in this document do so.

Why do we screen for TB?

The main aims of TB screening are to ensure that active TB is diagnosed and treated, that further transmission of the disease is limited, and that the risks of poor outcomes, including social consequences, to individuals, are minimized. TB screening in selected populations is supported by the World Health Organization and a resolution has been passed by the World Health Assembly in this respect.

The Australian Migration Act requires that entrants to Australia be free from tuberculosis. The IME aims to identify those DIBP clients who need treatment for active TB, or, in some instances, latent TB infection. This is an opportunity for Panel Physicians to be involved in providing a public health benefit for their own community as well as migrating populations.

Active case detection or screening for TB can include most or all of the following:

- medical history (part of the 501 medical examination)
- physical examination (part of the 501 medical examination)
- chest radiography (CXR) – the 502 CXR examination (plus 510 in some children)
- testing for previous exposure to tuberculous antigens – the 719 TB Test
- sputum testing for Mycobacterium TB (MTB) – usually part of the 603 chest clinic assessment
- testing for HIV disease – the 707 HIV test if active TB diagnosed.
The Medical History

A high index of suspicion is vital to the diagnosis of TB. Most visa applicants will be asymptomatic. The client's medical history must be reviewed by the Panel Physician for accuracy and understanding. Any discrepancies should be recorded in the relevant section in eMedical or on the paper Form 26.

The Panel Physician should make particular note of:

- symptoms suggestive of TB
- previous history of TB
- previous chronic illness requiring inpatient care or chest surgery
- previous or current illness suggestive of TB (such as persistent cough of ≥ 3 weeks’ duration, dyspnoea, weight loss, fatigue, anorexia, fever, night sweats and/or sputum production or haemoptysis)
- prior diagnostic evaluation suggestive of TB (such as sputum testing)
- close household contact of a person suspected of or diagnosed with active TB
- previous vaccination with Bacillus Calmette-Guérin (BCG)
- previous history of abnormal CXR findings
- travel or residence in a high incident TB country.

Symptoms

Classic symptomatology includes chronic cough (more than two weeks), haemoptysis, fever or night sweats, unexplained weight loss or anorexia, feeling generally tired and unwell.

In children, the clinical picture of TB may be different from adults and could be subtle. It might only include generalised findings such as growth delay (failure to thrive) or weight loss, fever and night sweats. In children less than two years of age there can be a different presentation and can overlap with other conditions such as pneumonia.

Previous treatment

Where someone gives a history of previous TB treatment, treatment records should be provided. These records should be comprehensive and include clinical findings, inclusive of serial weight measurements, results of chest X-rays and any laboratory testing, drug regimen (including dosages) in generic form, comment about whether the treatment provided was Directly Observed (DOT), response to treatment, including any adverse effects, as well as any disruption to the treatment regimen, and the final outcome. These records should be uploaded into eMedical. If not in English, a clear translation should be provided by the Panel Physician.

If records are unavailable, for example if the treatment was undertaken many years previously, or the client is unable to access, the Panel Physician should make note of this on the file and summarise as much as possible from the history provided by the client.

If there is a previous history of TB, the Panel Physician may wish to ensure that full treatment records are obtained. Important detail from these notes could include clinical signs, serial weight measurements, diagnostic tests, including drug susceptibility testing, drug regimens, duration of treatment and response. It is particularly important to identify the possibility of drug resistant TB (either multi-drug resistant (MDR), or extensively drug resistant (XDR)) in all applicants.

 Provision of as much information as possible is likely to be of assistance to the department in determining what, if any, additional testing might be required. It is particularly important to identify any possibility of drug resistant TB.

Prolonged hospitalisation

Long periods of hospitalisation or illness for lung disorders or any chronic illness might be suggestive of pulmonary or extra-pulmonary TB as a diagnosis. Panel Physicians need to seek as much information as possible when such a history is provided particularly in countries where significant stigma still applies to a diagnosis of TB.
Previous abnormal chest X-ray

If previous CXR images are available these should be uploaded if in digital format. If not in digital format, the CXR report or a comment on the previous XR image should be made by either the Panel Physician or the radiologist. Uploading a digitally scanned image or a high quality photograph of previous analogue images can sometimes be of assistance.

Household contacts

Any history of close household contact of a person diagnosed with active TB is significant and must be recorded. The nature of the relationship is also important as well as how long ago the contact was and whether it had been investigated by local authorities. Occupational contact with TB is not, in the absence of immunocompromise, considered to be a significant risk in the context of this medical and should not be recorded in the history.

Clients with a history of close household contact with TB will require additional testing if a visa applicant. A 719 TB test should be added in eMedical by the Panel Physician, regardless of the age of the client, and regardless of whether or not a CXR has already been performed. Other contacts who are not visa applicants should be referred to local TB authorities.

If the 719 TB test is positive, a CXR should be added if it has not already been performed.

All cases with a close household contact of active TB will be B graded, regardless of the results of the 719 TB test or the CXR.

Risk factors for reactivation of TB

Panel Physicians should be aware of other factors which may be associated with increased probability of developing the disease after infection (risk factors) or for reactivation of active TB disease. These include:

- younger age (<35 years age)
- malnutrition (body mass index less than 18.5)
- diabetes mellitus
- immunosuppressive medications (corticosteroids, cytotoxic chemotherapy, TNF alpha inhibitors, post solid organ transplant)
- chronic renal failure/haemodialysis
- silicosis
- post solid organ transplantation
- HIV infection
- gastrectomy/jejunoileal bypass surgery
- carcinoma of head or neck
- refugee background
- country of last residency.

Any abnormal findings or suspicion of previous or current disease should be recorded and the case ‘B’ graded (in most instances eMedical will automatically grade the case ‘B’).

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1 Systematic screening for active TB, WHO 2013
Physical examination

The physical examination must be comprehensive. Applicants must be asked to remove sufficient clothing to enable a complete chest examination (down to underwear). A chaperone must be offered and this must be recorded in eMedical.

The examination must pay particular attention to respiratory findings and needs to include:

- general appearance, including height and weight
- respiratory rate
- finger clubbing
- any respiratory distress, including cyanosis, and use of accessory muscles
- position of trachea
- inspection of the chest for chest shape and expansion, scars of scrofula, prior chest surgery
- percussion of the chest
- auscultation of breath sounds in the anterior, posterior and axillary areas
- examination of the lymphatic system, with particular emphasis on the cervical chain and axillary nodes in all clients.

Specifically, for the purposes of the IME, palpation of lymph nodes, with a specific emphasis on the cervical chain and axillary nodes, should be undertaken and documented.

It is also important to exclude signs of extra pulmonary TB, which can occur in virtually all organ systems and may co-exist with pulmonary TB. Most common sites are lymph nodes, pleura, bone/joint, genito-urinary tract meningeal, miliary (disseminated) and peritoneal sites.

Chest radiography - CXR 502 and 510 (PA and Lateral)

Radiographic techniques

- All CXRs taken should utilise digital technology (either computerised radiography (CR) or digital radiography (DR)).
- All adult CXRs should be taken in the posteroanterior (PA) projection to reduce cardiac magnification.
- In a correctly exposed film, the penetration should be such that one should be able to see all the thoracic intervertebral spaces.
- In an over-penetrated film, faint soft tissue lesions can be easily missed.
- In an under-penetrated film, pulmonary infiltrations can be over-diagnosed.
- Routine CXRs should be taken in full inspiration. This lowers the diaphragm to the level of the 10th or 11th rib posteriorly.
- The position of the patient should be such that the medial ends of the clavicles are equidistant from the spinous processes of the thoracic vertebrae.
- Rotation of the chest can make the side nearer to the film appear less translucent.
- The scapulae should be clear of the lung fields.
- The CXR beam should be centred at T5 or T6 vertebral body.
- The distance of the CXR tube to the film should be 180 cm (6 feet).
- All CXRs should include costophrenic angles.
- Apices should be clearly seen (without overlying clavicles).
If the lungs are of different translucencies one should consider:

- rotation
- poor screen / film contact in the cassette
- absent breast.

Ensure that the following artefacts are excluded:

- braided hair overlying the apices, which can mimic a lesion
- static marks
- dirty screens
- nail marks
- foreign bodies in cassettes.

**Special views**

A coned apical lordotic view should be done for suspicious upper lobe opacities in the upper lungs, including those over ribs, clavicles or other structures, and a lateral decubitus view or lateral view or ultrasound for costo-phrenic angle blunting to exclude pleural effusion.

Computerised Tomography (CT) scans should not be performed to screen for TB and should only be performed where clearly clinically indicated for non-TB reasons (for example, where malignancy is suspected).

**Paediatric X-rays**

CXRs are required in those 11 years of age and over, or in children aged from two to 10 years of age (inclusive), who have a positive Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA). CXRs may also be required if there are clinical indications.

For children under 11 years of age requiring a chest X-ray, lateral views should be done in addition to PA view.

Radiation exposure should be kept to a minimum.

Correct collimation (narrowing of the beam so that only the target area is exposed to decrease scatter, which degrades the image, and to protect the applicant) should be adequate to include the chest only.

Pelvic shielding should be used.

**Radiation safety**

Radiation safety should be maximised by:

- routine use of wraparound lead shielding for all applicants. Double lead wrap around shielding for all female applicants of child bearing age. See below for further detail regarding pregnant applicants.
- hanging lead shields – do not fold as this may crack the lead and allow radiation leakage
- testing the integrity of lead shields annually by exposing them on film or using fluoroscopy
- selecting correct plate size
- conducting X-ray beam collimation
- ensuring correct radiography procedures and machine settings are used to minimise repeat exposures being required for technical reasons
- avoiding unnecessary additional X-rays or scans, in particular CT scans, unless clearly clinically indicated (for example, suspicion of malignancy)
- minimising radiographer exposure
- ensuring all staff in the radiography working area wear dosimeters (radiation badges).
Chest X-ray image identification

Following proper applicant identification protocols, the CXR image must bear the date of the procedure, applicant’s name and date of birth in English, as well as the name of clinic. The passport number should ideally be included. The Gregorian calendar should be used.

CXRs should be submitted as DICOM files (Note: in eMedical files are limited to 350-500kb in size); if burning images on a CD, burn the full DICOM image.

Chest X-rays (CXRs) should use digital radiography (either computed radiography CR or direct digital radiology DR). Chest X-ray examinations are completed by uploading the compressed X-ray image in DICOM format and reporting in eMedical 502, or by attaching the paper chest X-ray examination report (Form 160) to the analogue chest X-ray film.

Chest X-ray interpretation

CXRs should be interpreted by designated radiologists and the X-ray report reviewed by Panel Physicians.

CXRs should be interpreted by radiologists with particular attention paid to radiographic manifestations of TB. Radiological review must include the lungs, hila, mediastinum and pleura. Should the CXR appear suspicious for active TB the radiologist must inform the Panel Physician immediately. CXR reports and images must be reviewed by Panel Physicians for correlation with history and clinical findings.

Based on clinical and/or radiological findings, further investigations will be requested. These include:

- TB smears and cultures done on three sputa collected under direct observation on three consecutive mornings
- repeat chest X-ray with a minimum period of three and preferably six months between X-rays.

All the following findings may be associated with TB and potentially trigger additional investigation depending on country requirements.

Findings suggestive of active TB or other conditions

- Any cavitating lesion OR “fluffy” or “soft” lesions felt likely to represent active TB
- Pleural effusion
- Apical fibro-nodular/fibro-calcific lesions or apical micro-calcifications
- Multiple/single pulmonary nodules/micro-nodules (non-calcified or poorly defined)
- Isolated or multiple hilar or mediastinal mass(es)/lymphadenopathy (non-calcified Single/multiple pulmonary nodules/masses ≥ 1 cm
- Non-calcified pleural fibrosis and/or effusion
- Interstitial fibrosis/parenchymal lung disease/acute pulmonary disease
- Notable apical pleural thickening (rough or ragged inferior border and/or ≥ 1cm thick at any point)

Minor findings, occasionally associated with TB disease

- Solitary Granuloma (< 1 cm and of any lobe) with an unremarkable hilum
- Solitary Granuloma (< 1 cm and of any lobe) with calcified/enlarged hilar lymph nodes
- Single/Multiple calcified pulmonary nodules/micronodules with distinct borders
- Calcified pleural lesions
- Costophrenic Angle blunting (either side above the horizontal) if proven with additional view or ultrasound to represent thickening, not fluid.
Minor findings which in isolation are not usually associated with TB disease and require no action other than noting include:

- single fibrous streak/band/scar
- pleural capping with a smooth inferior border (<1cm thick at all points)
- unilateral or bilateral costophrenic angle blunting (below the horizontal) if proven with additional views or ultrasound to represent thickening, not fluid
- calcified nodule(s) in the hilum/mediastinum with no pulmonary granulomata.

Panel Radiologists should report all abnormalities of clinical concern and their possible interpretation and cause in the 502 comments field in eMedical or on the paper Form 160. If the Panel Radiologist reports X-ray findings which are highly suspicious of active TB (Question 7), then eMedical will automatically generate a 603 referral for further investigation. Such changes include as outlined in the first list on the previous page such as - cavitation, effusion or soft infiltrate in adults. In children, findings are often more subtle and may include parenchymal change and lymphadenopathy. In these cases, Question 7 (are there strong suspicions of active TB?) should be answered ‘yes’.

If in doubt, the Panel Radiologist should record the findings in Question 6, but tick “no” to Question 7. The MOC will then provide an opinion about whether further investigation is required. Please note that hilar lymphadenopathy will not auto-generate a 603 referral but Panel Physicians should refer immediately if clinically appropriate.

Chest X-ray reports and images must be reviewed by Panel Physicians to correlate with history and clinical findings.

For paper cases where there is a high suspicion of active TB, the Panel Radiologist or Panel Physician should immediately refer the applicant for sputum testing and a chest physician referral.

**Tuberculin Skin Test (TST) and Interferon Gamma Release Assay Tests (IGRA) –719 TB Test**

Tests for latent M. tuberculosis infection (LTBI), Tuberculin Skin Test (TST) and Interferon Gamma Release Assay (IGRA) may be required in one of two situations – contact tracing and initial screening in children. These tests play no role in the diagnosis of active TB except as mentioned above as a primary screening tool in younger asymptomatic children. Any applicant who has symptoms of TB should move directly onto more formal diagnostic testing of CXR and sputum analysis.

**Paediatric screening**

Children from high TB burden countries are a highly vulnerable group and testing for previous exposure to MTB is designed to strengthen screening for active TB to improve detection of this disease and it will also identify those children with latent TB infection (LTBI).

LTBI is a condition where a person is infected with Mycobacterium TB but does not have active TB disease. Testing for LTBI would normally mean that there is an intention to treat. Panel Physicians must therefore provide counselling to parents before testing on the need for consideration of treatment and/or longer term follow ups if the test is positive.

DIBP Policy requires that the following clients undergo a 719 TB Test (either a TST or IGRA).

- Children, aged from two to less than 11 years of age, who are:
  - from a higher risk TB country and are applying for a permanent or provisional visa
  - applying for refugee or humanitarian visas
  - asylum seekers within Australia
  - applying for a temporary visa and declare close household contact with TB.

- All children aged less than two years of age who declare close household contact with TB or display clinical symptoms of TB will also require additional testing irrespective of the visa applied or country risk level.
Both TST and IGRA measure the immune response to Mycobacterium tuberculosis antigens. This creates an initial triage for further screening. Any positive reaction to either of these will require a chest X-ray and potentially further investigation as outlined in greater detail below.

**Choice of TST or IGRA**

TST and IGRA are seen to be broadly equivalent in respect to diagnosis of LTBI and as such DIBP has no specific preference as to which test is used. Parents or guardians should be counselled about cost, client service aspects and access to specific tests.

The Panel Physician should be aware that the Tuberculin Skin Test (TST or Mantoux test) may be positive if there has been previous Bacillus Calmette-Guérin (BCG) vaccination, especially in the previous five years. IGRA tests, being more specific, are therefore preferred in children under five years who have received the BCG vaccine.

IGRA tests, however, may result in indeterminate results in children under five years, so, in the absence of previous BCG vaccination, TST is generally preferred.

**Exemptions from TB screening test in children**

Where there is written documentation from a physician of previous TST reaction greater than or equal to 10mm, or a positive IGRA, there is no need for a new TST or IGRA to be completed. This documentation must include date of test, millimetres of induration, type of purified protein derivative (PPD) used, and the testing physician’s name and should be attached to the medical examination/eMedical. Applicants with a previous positive test as outlined should proceed directly to CXR, even if a subsequent test has been negative.

If there is written evidence of a microbiological/laboratory diagnosis of previous TB (ie positive smears or cultures from a sputum specimen or other site), or a positive TST, then a new TST is not required. This should be noted this under the comments tab in the 719 TB test (eg past history of TB) and proceed directly to CXR.

If the CXR is normal and there are no other clinical signs then the panel physician should submit previous treatment records and grade B.

If the CXR is abnormal or there are clinical signs then a new referral is required

If there is no written documentation of a microbiological/laboratory diagnosis of previous TB or a previous positive TST, then the panel physician should proceed as usual (ie should perform the TST).

Note that previous BCG vaccination is NOT an exemption to TB screening test.

As noted, the additional screening test for children is either a TST or an IGRA. The Panel Physician should consider the availability of these tests within the specific country and discuss with the applicant the advantages or disadvantages of each test as well as consequences if the test is positive.

**Note:** where the TST or IGRA is required, Panel Physicians must undertake efforts to ensure the test is available and applicants receive the required test.

**Costs of TB screening test and related X-ray examinations must be displayed at the clinic and itemised on the receipts.**

**TST (Mantoux test)**

Purified protein derivative (PPD) should be administered intradermally by the Mantoux method. Ideally, preparations should be equivalent to 5TU PPD-S. However, in countries where such preparations are unavailable, Panel Physicians should use PPD preparations that are approved for use by their Ministries of Health. The type of PPD used should be documented.

Additional technical instructions should be provided by the Panel Physician’s chosen provider (for example, pathology or pulmonology).

The TST should be administered by suitably qualified staff and must be read between 48 and 72 hours. The result in millimetres (mm) induration needs to be recorded each country’s reporting mechanism. If the TST is negative, nothing further is required other than the recording of information. If the TST is greater than or equal to 10mm (or in close household contact ≥ 5mm), at minimum chest radiography (CXR) is required (see below).
IGRA

IGRA tests are blood tests which measure a component of cell-mediated immune reactivity to Mycobacterium TB in fresh whole blood. QuantiFERON-TB Gold®, QuantiFERON Gold® In Tube, or T-Spot tests are acceptable. Panel Physicians should follow manufacturers’ written instructions for performing the examinations and interpreting the results.

Note there are relatively few published reports documenting the performance of IGRAs in young children (less than five years of age). Obtaining sufficient blood can be difficult, and there is concern those IGRAs may perform differently in very young children, who are at greater risk of a poor outcome in infection is undiagnosed.

For the purposes of the IME, an indeterminate test result should be managed as a negative result in that if the client is asymptomatic, further screening is not required. However these cases should be ‘B’ graded as further testing will be arranged when the client arrives in Australia.

All IGRA test results should be documented in their unit of measurement, even for those with negative or indeterminate results. For all positive tests, a CXR is required (see below) as a minimum.

Results of the TB test and what to do next

Where the TST is ≥ 10mm (≥5mm in close household contact) or there is a positive IGRA or where clinical examination is suggestive of TB, a standard PA projection is required as well as lateral view in children less than 11 years of age.

If the CXR shows signs consistent with a strong suspicion of active TB, “possible” active TB, or where TB might need to be excluded, sputum testing and pulmonologist (preferably paediatric) review are both immediately required.

All these cases should be ‘B’ graded.

Refusal to undertake IGRA and TST

In the rare situation where IGRA is refused by the parents or guardians of child clients, Panel Physicians should offer a TST as an alternative if available. This also applies in the reverse where a TST is refused, an IGRA should be offered if available.

If the Panel Physician has well established processes and trained staff this situation should be rare. Panel clinics should do all possible to minimise the trauma for children and reassurance of parents. They should also counsel parents that the visa application may not proceed without the test being undertaken.

Panel Physicians should not proceed to X-ray children where an IGRA and TST have been refused. If both are refused, the 719 examination should be recorded as incomplete with the drop-down comment selected to indicate that the applicant refused the testing. The client should not be offered chest X-ray (examinations 502 and 510) as an alternative. Please contact Immigration Health in these situations or where an alternative test is not available.

Special situations: indications for additional testing (regardless of visa category)

For children less than two years of age from high burden TB countries and children of any age who are immunocompromised and/or displaying symptoms of TB, specific action is required (please refer to contact tracing section of these Instructions.

- Children under two years of age from higher TB burden countries who are close household contacts with active TB

These children are especially vulnerable and at risk of developing active disease. As noted above, any child who is a close household contact of active TB should have the 719 TB test, even if under two years of age. In addition, any child in this group should undergo CXR examination and specialist paediatric review, regardless of symptomatology or clinical findings, or the result of the 719 TB test.
- **Children under five years of age from higher TB burden countries who are close household contacts with active TB**

  Active TB needs exclusion. Once active TB has been excluded, these children should be provided with prophylactic treatment for latent TB infection (LTBI). This should be initiated by the treating paediatrician or chest specialist, with parental consent.

  Commencement of prophylactic treatment for LTBI should not delay submission of the case to DIBP.

  The only exception to this rule is for those children who are close household contacts of active TB which has been confirmed as Multidrug Resistant TB (MDRTB). These children should NOT be provided with prophylactic treatment offshore due to the complexities involved. These children will be monitored on arrival in Australia.

  These cases will be B graded and comment should be made indicating close household contact with active TB and prophylactic treatment for LTBI has/has not commenced.

- **Children of any age displaying symptomatology or clinical signs, or who are immunocompromised**

  While these children should be screened for LTBI as per policy, this is not a diagnostic test for active TB and as such in addition to TST or IGRA, these children should be immediately referred for CXR and specialist review.

**Sputum testing in children less than 11 years of age**

  Sputum testing should be performed in accordance with the Instructions below, that is - three specimens, which should undergo microscopy for acid-fast bacillus (AFB), as well as culture for mycobacteria, and confirmation of Mycobacterium species, at least to the M. tuberculosis complex level.

  It is recognised that children under eight years of age may have difficulty producing sputum. Applicants unable to produce sputum specimen would be required to have alternative methods of sputum collection, such as early morning gastric aspirates, or sputum induction, or both. Newer technologies such as Xpert® MTB/RIF on faecal specimens are also showing promise and while not routinely recommended may be considered in highly suspicious cases that are negative.

  Results should be made available to specialist pulmonologist/paediatrician as part of the clinical review.

**Women and procedures followed for pregnancy**

  CXRs are the routine method to screen female applicants, who could be pregnant, for TB. Panel Physicians must ask female applicants of child bearing age about pregnancy and the last menstrual period.

  Almost all imaging tests expose the foetus to such low levels of radiation that they are not a cause for concern. The International Commission on Radiological Protection (ICRP) has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation. The ICRP has stated that deterministic risks such as these would not be expected to occur in an embryo or foetus that had been exposed to less than 100 mGy of radiation. If the pelvis or abdomen is not in the direct beam the foetal dose is usually <1 mGy. The typical foetal dose of a CXR is 0.001–0.01 mGy.

  Any radiological examination of the mother that does not involve the direct irradiation of the foetus will deliver a comparatively low dose to the foetus. (Ref: HPA: Protection of Pregnant Patients during Diagnostic Medical Exposures to Ionising Radiation (RCE-9) March 2009.) People are exposed to background radiation in their daily activities which varies widely in different parts of the world due to the radioactivity of the soil, latitude, height above sea level and lifestyle (predominantly indoors or outdoors).

  The radiologist responsible for the radiological examination should take all reasonable steps to advise the pregnant applicant of the potential risks of radiation exposure of the foetus. For pregnant patients, written informed consent is only recommended if the pelvis is in the direct beam and this consent is required prior to the radiological exam. If consent is not provided, the Panel Physician should provide the option of delaying the CXR and TB clearance until after delivery.
Panel Radiologists have an ethical obligation to ensure pregnant applicants are adequately protected, using double wrap around abdominal and pelvic shielding when appropriate. Be vigilant in avoiding unnecessary radiation exposure. Panel Physicians must adhere to national guidelines where applicable.

45 Diagnostics

Sputum testing

Indications

If active TB is suspected from the medical examination or X-ray findings, sputum collection is required. Indications for immediate sputum testing include:

- haemoptysis
- any infectious or post infectious X-ray changes in a person who has clinical signs or symptoms of TB
- any infectious or post infectious X-ray change in an HIV positive or otherwise immunocompromised person
- radiological findings which indicate a strong suspicion of active TB. In adults such findings include cavitation, infiltration or effusion. In children, any infiltrate or subtle finding in a child with a positive TB test is strongly suspicious of active TB. In such cases the radiology report, should include a positive answer to Question 7 in eMedical, and as such would automatically generate a request for additional testing in eMedical. In paper cases, the Panel Physician should make the appropriate arrangements directly.

Sputum testing and clinical specialist review may also be requested following assessment of the case by a Medical Officer of the Commonwealth in Australia. If Panel Members believe specialist referral and sputum testing is indicated, but they are technically unable to add a 603 medical examination, they should contact IHB and seek assistance.

Sputum collection guidelines

Sputum collection must be supervised in a clinic or laboratory, that is, it must not be collected at home. Ideally it should be collected at the laboratory where processing will take place, provided the laboratory staff perform appropriate identity checking. If this cannot be assured, the collection should take place at the panel clinic. Panel Members should maintain suitable procedures.

The collection must occur in a suitably ventilated location such as a negative-pressure booth or a well ventilated outdoor area. Staff performing the collection must be provided with appropriate personal protective equipment, including gloves, and N95 face masks or equivalent.

In locations with TB laboratories that have been designated by DIBP, these facilities must be used for sputum processing. Results from other laboratories in such locations will not be considered in their immigration health assessment. A list of approved TB facilities appears at Appendix D.

Administrative arrangements

- Information must be provided to the client prior to attendance in respect of time of attendance (first thing in the morning) and they must not have breakfast or clean their teeth.
- On attendance confirm the identity of the applicant.
- Ensure the applicant is fasting.
- Explain the collection procedure to the applicant.
- Use appropriate disposable equipment.
- Safe storage and disposal of clinical waste.
- Accurate specimen identification using non-removable labels which comprise of:
  - applicant’s demographic data
Panel Physician’s name

date of collection

time of collection

specimen type and site

Sputum collection

Sputum collection and the laboratory processing of sputum samples should take place with appropriate infection control measures in place as these procedures constitute a biohazard.

Three consecutive morning specimens are required in most situations. The three specimens of 5-10 ml of sputum are required at least 24 hours apart, preferably on consecutive days, in the early morning. Sputum must be collected directly observed in an appropriate and safe area (for example, well ventilated outdoor site or negative pressure indoor chamber) with standard operating procedures, including, as an example, following mouth rinsing with saline solution, distilled or purified water. Check that sputum is collected, not just saliva.

The collector or the supervisor of the laboratory or the laboratory technician preparing the specimen can discard any specimen found to be saliva and not sputum. In this case the applicant needs to return for collection.

Applicants should be sitting on a stool and have access to tissues to cover the mouth between coughs. All applicants need to be instructed to take three deep breaths, and on the forth deep breath to cough. The cough should use an abdominal contraction and not be just from the upper chest or throat.

The collector needs to listen to the applicants coughing to ensure that the cough comes from the stomach and not from the chest or throat. If an applicant continues to cough from the throat or is unable to cough from the stomach, they should be asked to return the following day.

Applicants must not clear their nasal passages into the back of their throat and present this as sputum specimen. Specimens must never be pooled.

Induced sputum collection (and bronchoalveolar lavage) should be limited (see below) but can be used when felt appropriate.

It is essential that all staff are appropriately protected using gloves and masks and are trained to deal with spills. The use of P95 or N95 masks is recommended.

Applicants can be provided with the following instructions:

- Rinse mouth with water and spit out.
- Cover mouth with a tissue.
- Sit on the stool provided.
- Hold the collection cup and take the top off.
- Take four very deep breaths and on the fourth deep breath cough from deep in the chest. (The cough should use an abdominal contraction and not be just from the upper chest or throat).
- Hold your arm around your stomach and cough deeply.
- Collect the sputum in your mouth.
- Gently spill the sputum into the cup.
- Put the top on the cup and seal shut.
- Give the container to the nurse.

This process should be repeated until an adequate specimen has been collected.

Visual aids including video demonstrations of collection techniques are strongly recommended to assist clients with providing an adequate specimen.
Sputum testing in children

It is recognised that children under eight years of age may have difficulty producing sputum. Clients unable to produce sputum specimens are required to have alternative methods of sputum collection, such as nasopharyngeal aspirate, early morning gastric aspirates, or sputum induction, or both. Newer technologies such as Xpert MTB/Rif on stool and urine specimens are also showing promise and while not routinely recommended may be considered in highly suspicious cases that are negative. Results should be made available to specialist pulmonologist/paediatrician as part of the clinical review.

Use of induced sputum

Nebulised saline induction can be utilised especially for persons from whom a satisfactory sputum specimen cannot be obtained otherwise, including children as young as three years. A gastric aspirate, which is preferred for children, or bronchial washings are also acceptable if sputum cannot be obtained (but sputum is preferable for adults). Induced sputum collections often have a higher degree of positive findings than regular collection, especially when the induced sputum is used as the second sputum collection. The collector should be wearing an appropriate mask and well-fitting gloves during the collection process.

There are several methods of obtaining a specimen:

- Inhalation of an aerosol of sterile hypertonic saline (3-15 per cent), usually produced by an ultrasonic nebuliser, can be used to stimulate the production of sputum. Even though aerosol-induced specimens may appear thin and watery, they should be processed. The specimen should be clearly labelled as “induced sputum” so that it will not be discarded by the laboratory as an inadequate specimen. Even when alternative methods are used, three specimens are required at least 24 hours apart, preferably on consecutive days.

- Sputum induction can be used for children as young as three years old.

- A gastric aspirate / nasopharyngeal can be used for all ages (but sputum is preferable in adults) and may be especially helpful for young children. If gastric aspirates are used on young children, the same number of specimens should be obtained as would otherwise be collected. In addition, the candidate must have had nothing to eat or drink for a period of at least six hours prior to the procedure.

- If broncho-alveolar lavage is used to obtain specimens, the applicant only needs to undergo the procedure once. During the procedure, two specimens should be obtained from different locations.

Inability to produce adequate sputum

On occasion clients may claim that they are unable to produce three separate sputum samples. It is worth remembering that Australian regulations stipulate that the client must be “free of TB” prior to entry to Australia, and the onus is on the client to demonstrate that this is the case. Experienced laboratory staff advise that sputum collection is generally possible in almost everyone. However, if Panel Physicians have exhausted all avenues, including those of induced sputum, they should:

- provide whatever sputum results are available with a comment that the client is unable to produce specimens

- attach the pulmonologist report

- repeat the CXR three months after the initial film, with comment on radiological stability

- submit the case in eMedical (it may be necessary to finalise as “incomplete” if all health examinations have not been provided).

The MOC will then provide further advice about any additional tests required.

Sputum sample storage and transport requirements

Specimens must never be pooled. That is each sample must remain in its own collection container at all stages of the process.

The specimen should ideally be collected onsite at the laboratory where it will be tested. If not, sputum samples should be transported to the laboratory, within one hour of collection. If it is not
possible for the sample to be transported within one hour, the sample should be stored in refrigeration at 4 Degrees Celsius or 39.2 Degrees Fahrenheit but not frozen, and protected from light. If the samples have to be transported to another site, careful procedures for packaging and shipment should be followed.

Specimens received in the laboratory should be processed within 24 hours of receipt.

If the samples have to be transported to another site, careful procedures for packaging and shipment should be followed as detailed below.

If transporting to a local laboratory specimens must be in individual jars and held upright with separation between specimens and structures in place to prevent spillage (which might include sealable plastic bags) and contamination between specimens as indicated in the picture below.

When transporting large distances by plane or other transport the specimens must be contained in three separate levels. See diagram below.

The first is a leak-proof container which is surrounded by absorbent material. This then goes into a leak-proof secondary package such as a sealed plastic bag, which itself is surrounded by cushioning material and contained in a rigid outer package. There is no need for refrigeration if the transport time is short but consideration can be given to this if delays at airports are expected or the ambient temperature is high. In these circumstances it is best to include a thermometer inside the box with an indication of the temperature at the time of packaging.

Specimens received in the laboratory should be processed within 24 hours of receipt.

**Sputum smear**

The two staining methods of either Ziehl-Neelsen (ZN) or fluorescence auramine can be used to investigate the presence of acid fast bacilli (AFB). Fluorescence Auramine stain (FAS) is preferred. A laboratory technician should examine a minimum of 30 slides a week in order to maintain sufficient expertise in microscopy. If using ZN at least 300 high power fields must be read at 1000x (a minimum of 15 minutes) before a specimen can be stated to be negative. Reporting guidelines must be used.
which for ZN includes 4+ (>9 per field), 3+ (1-9 per field), 2+ (1-9 per 10 fields), 1+ (1-9 per 100 fields) or if less than 10 bacilli per 300 fields – the exact number seen.

For FAS the reporting at 250 magnification is 4+ (>90 per field), 3+ (10-90 per field), 2+ (1-9 per field), 1+ (1-9 per 10 fields) or if less than 1-2 per 30 fields – the exact number seen.

For both if no AFB seen the recording is zero.

**Duration of culture**

Laboratories have the choice of using liquid or solid media for culture. The advantages of using liquid media are the availability of results in a shorter space of time. Some laboratories perform both solid and liquid cultures in parallel which provides improved outcomes but this is not mandatory.

**Note:** Specimens must not be pooled.

In order to declare a negative result, specimens must be cultured for a minimum of six weeks if using liquid media and eight weeks in solid media unless a positive result is obtained earlier. Reports must indicate the results for each specimen individually (that is, it is not acceptable to simply indicate “culture negative” for all three specimens).

Confirmation of the mycobacterium species, at least to the M. tuberculosis complex level, is required. A single positive culture for M. Tuberculosis, in general, is considered to define active disease.

**First line Drug Susceptibility Testing (DST)**

All positive culture isolates must be tested for susceptibility to first-line drugs at a minimum. Presently, first-line DST includes testing for susceptibility to isoniazid, rifampicin, ethambutol, pyrazinamide and streptomycin.

**Second line Drug Susceptibility Testing (DST)**

Mono resistance to either ethambutol or streptomycin does not routinely require second line DST but this is desirable.

Resistance to isoniazid or rifampicin and any other resistance pattern, must include second-line DST. This DST should include testing for susceptibility to fluoroquinolone, ethionamide, capreomycin, amikacin and para-aminosalicylate sodium (PAS) at a minimum.

**Use of molecular testing**

The use of molecular testing on sputum samples is likely to become more widespread in coming years. Panel Physicians should remember that smear and culture remains the reference standard and that while molecular testing has a role, it does not replace smear and culture.

Molecular tests can be useful in the following situations:

- Smear positive clients (to allow early identification of possible drug resistance).
- Treatment relapse (that is, suspicion of drug resistance).
- Children, in whom faecal specimens can be considered by specialists when sputa are negative but there is high suspicion of activity.
- Countries where culture facilities are unavailable, and transport to such a facility impractical. This should occur rarely with approval from Immigration health Branch and must be recorded on the client’s file.
- Situations where there is suspicion of “pre-treatment” (that is, where clients may be self-treating with anti-tuberculous medication prior to sputum collection).

In the immigration medical examination setting, if available, molecular testing for isoniazid and/or rifampicin resistance can be clinically useful for all cases which are smear positive (and cultures and DST are pending), as it will allow faster identification of drug resistance and alteration of treatment regimens. Panel Physicians that have access to these tests may use them for faster identification but not as a culture substitute for clearance purposes.

In addition, in locations with a high rate of non-tuberculosis mycobacteria (NTM), use of molecular tests can more quickly confirm M. tuberculosis versus NTM. Molecular tests can be used to augment but are not an accepted substitute for tuberculosis culture, which is required in all cases where sputum
is collected. This is because the Hain GenoType® MTBDR plus (that is, line probe) assay and the Cepheid Xpert® MTB/RIF test are not as sensitive as liquid culture and can only determine resistance to isoniazid and rifampicin (Hain) and rifampicin alone (Cepheid). Therefore, sputum cultures are necessary to achieve the highest sensitivity and determine the full drug susceptibility profile. Panel Physicians that have access to these tests may use them for faster identification but not as a culture substitute for clearance purposes. Drug susceptibility testing must always be done to confirm sensitivity patterns.

Before undertaking molecular tests in situations of suspected pre-treatment, Panel Physicians should await instructions from Immigration Health.

**TB alerts**

Immigration Health Branch must be notified immediately by email in the following situations:

- Multi–drug resistant or Extensively Drug Resistant TB has been identified.
- Clients who default on treatment or treatment failure.
- Where the Panel Physician becomes aware of a diagnosis of TB after the client’s case has been finalised.

Cases processed on paper (that is, not in eMedical) who are smear positive – see below.

The following instructions relate only to clients whose medicals are on paper (Form 26)

If positive AFB (smear) results are obtained from a paper case, the Panel Member must, within 48 hours, notify Immigration Health by email. The email’s subject line must include the title: Notification of Active TB case – HAP ID: xxxxxx, ‘Medical–in-Confidence’.

There is no need to notify Immigration Health if the smear is negative but the culture is positive. Details required for notification of an active TB case are:

- family name
- given names
- date of birth (dd/mm/yyyy)
- HAP ID.

Panel Physicians should notify Immigration Health even if the client indicates that they are withdrawing from the visa process.

**46 Treatment**

**Decision to initiate tuberculosis treatment**

Quality TB management requires implementation and maintenance of complementary set of activities to support good clinical practice. These include:

- ongoing staff training and development
- systematic data collection and analysis
- laboratory quality assurance and management
- radiology quality assurance and management
- national TB Programme (NTP) partnership and liaison.

It is the responsibility of the Panel Physician to ensure these activities are optimised within their referral network or TB management site.

TB management of individual applicants should be supervised by the Panel Physician (even where the treating physician is an external provider). Panel Physicians should act as case managers to ensure
that the requirements of treatment completion, public health responsibility, external notification and resettlement needs are met.

A TB specialist and/or Panel Physician will take into consideration clinical, microbiological and radiological findings when assessing the need to treat. Smear-positive cases, as well as smear-negative and culture-positive cases, always require treatment; there may be some cases where smear and culture are negative but there are good clinical or radiological grounds to treat. Anti-tuberculous treatment is nearly always started without knowing the antibiotic susceptibilities of the causal organism and the initial regimen should comprise of the four drugs isoniazid, rifampicin, pyrazinamide and ethambutol. This will be tailored where susceptibilities are identified and are one advantage of molecular testing with Xpert MTB/RIF.

Treatment should be initiated through directly observed therapy (DOT) for all applicants undergoing treatment.

Isolation of applicants

For those facilities with capacity for isolation, this should be considered for persons with:

- symptomatic presentation that is highly consistent with pulmonary TB
- smear-positive PTB
- infectious persons with infants or immune-compromised family contacts
- persons requesting assistance with treatment initiation due to disability or substance abuse or other prohibitive factors
- suspected or confirmed MDR or XDR TB

In all cases, patients should be educated about the mode of transmission and the risk of infection to others. Instruction should be provided on cough etiquette, the need to stay within the isolation area, and the importance of maintaining adequate ventilation.

Face-masks should be readily available to those with positive sputum smears until such time as smear conversion occurs. MDR cases should wear facemasks until culture conversion has been documented as above. Patients must be shown how to wear a surgical mask and instructed in the need to do this when outside the isolation area. Visitors should ideally be received in open-air environments or other well-ventilated environments.

Where isolation facilities are not available, patients should be educated in additional means of reducing transmission risk, including household isolation or other means of minimising family or social contact.

Treatment

Treatment of tuberculosis disease should occur in compliance with international standards and in cooperation with NTPs wherever possible. Internationally recognised guidelines include those published by the World Health Organization (WHO), http://www.cdc.gov/mmwr/PDF/rr/rr5211.pdf, the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), Infectious Disease Society of America (IDSA), the Canadian Tuberculosis Standards, Guideline for Tuberculosis Control in New Zealand, National Institute for Health and Care Excellence (NICE) Tuberculosis clinical guidelines 117 and the Communicable Disease Network Australia (CDNA) National Tuberculosis Guidelines.

Information on TB treatment can be accessed through the Centres for Disease Control and Prevention, Division of Tuberculosis Elimination especially in Table 2 of the ATS-CDC-IDSA Treatment of Tuberculosis recommendations which describe standard short course TB chemotherapy regimens for pan-susceptible organisms. Table 3 describes dosing requirements for adults and children and appears as Appendix A of this document.

See: www.cdc.gov/tb/default.htm
Directly Observed Therapy (DOT)

Treatment should be delivered as DOT. DOT is an adherence-enhancing strategy in which a healthcare worker or other trained health-care staff member watches a patient swallow each dose of medication and documents the dose. DOT is the standard of care for all patients with TB disease and also helps reduce the development of drug resistance.

Applicants must be counselled about why DOT is a requirement for TB treatment, that is, it reduces the chance of drug resistance and enables greater likelihood that the applicant will be cured of TB. Consequently, under the differing legislative requirement of countries assessed as being free of TB, completion of treatment would allow a timelier visa decision. If they are unable to comply with DOT, then this must be documented in the file. The applicant’s medical records should be included in the referral to the proposed treating clinician. During treatment, sputum monitoring must still be undertaken at a designated laboratory.

Applicants need counselling that non-adherence to DOT may lead to delays in medical clearances or non-grant of visa if it cannot be satisfied they are free from TB.

Documentation should be present to illustrate the continuum of care and also to facilitate all treatment undertaken and side effects experienced by the applicant. This documentation is moreover important in assisting the future clinician when the applicant arrives in the receiving country, should there be a need to re-treat.

Non-Tuberculous Mycobacteria (NTM)

The treating physician may also use their clinical judgement to stop treatment on applicants whose culture only grows non TB mycobacteria (NTM) and when tubercular disease is clinically felt to be absent.

Treatment of Multi Drug Resistant – Tuberculosis (MDR-TB)

The treating specialist and/or Panel Physician should treat MDR-TB according to internationally recognised guidelines. It is acknowledged Panel Physicians may be bound to refer to their own country MDR specialist resources.

All cases identified with drug resistance are reviewed by an expert panel in Australia at the completion of treatment. This panel advises MOCs about whether the client can be considered “free from TB” and the process is managed internally by DIBP. If treatment provided is considered to have been inadequate, or there is no evidence provided to support the treatment regimen administered, the panel may recommend further surveillance in the client’s home country. If this occurs, the MOC will provide a deferral notice indicating what is required. This may include a recommendation for ongoing sputum analysis for a lengthy period of time. In these cases, Panel Physicians should follow these instructions and submit the case for MOC assessment ONLY at the end of this period. If the client advises the panel that they wish to withdraw from this process, the panel should then finalise the case as “incomplete” indicating this.

Treatment monitoring in MDRTB is more complex and needs the assistance of specialist care. This enhanced monitoring is required given increased risk of drug toxicity associated with complex regimens of extended duration. Prolonged isolation and treatment durations necessitated by MDRTB also increase potential for stigmatisation and other negative psycho-social responses to treatment.

In addition to standard monitoring, monthly electrolyte profiles are advisable for patients taking aminoglycosides or capreomycin. Patients should be monitored closely for hearing disturbance which if detected may be further quantified with audiometry. Three-monthly thyroid function testing is advisable for patients taking PAS or ethionamide. Extended treatment with ethambutol will necessitate ongoing monitoring of vision.

Chest X-rays should be obtained at or after three months’ treatment and then at least at six-monthly intervals and more frequently if clinically indicated. Monthly sputum specimens should be obtained for microscopy and culture.

Persons isolated for MDR treatment require psychiatric or psychological evaluation at the commencement of treatment and close psychological monitoring and support thereafter. This is especially important with patients taking Cycloserine, for which depression and psychosis are known potential side-effects.
When physicians need assistance with complex treatment scenarios, they should seek guidance from DIBP. Panel Physicians should email case details (including client name, date of birth, and electronic identifier) for review by a DIBP Senior Medical Officer who can access specialist advice if necessary to health@border.gov.au.

Monitoring during treatment

Chest X-ray monitoring

The use of monitoring CXRs during TB treatment is a clinical decision left to the judgement of the treating physician and their treatment programme. Thus, monitoring CXRs are not a health processing requirement during treatment. However, CXRs during the course of treatment can help monitor progress and gauge therapy success. Monitoring CXRs may be most helpful in circumstances such as, but not limited to, when the applicant had findings such as cavities, extensive findings, or pleural effusion. A repeat CXR can also be helpful if the applicant does not appear to be responding appropriately during treatment or has new symptoms.

Note: A CXR is required at the end of treatment.

Laboratory monitoring during and after Tuberculosis treatment

Sputum testing during treatment (that is, in-treatment monitoring), even if that treatment is being provided through a different facility, should also be performed by the approved facility in locations where one is available.

Culture and drug-susceptibility testing results are used to determine the frequency of laboratory testing during treatment.

Children less than 10 years of age with pan-susceptible or culture-negative tuberculosis who cannot provide sputum specimens will not need to provide induced sputum or gastric aspirate specimens during treatment, unless their clinical course warrants an evaluation.

- **Pan-susceptible**: two sputum specimens must be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy, until cultures are negative for two consecutive months.

- **Resistant to only one drug** (including resistant to only isoniazid or rifampicin): two sputum specimens must be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy, until cultures are negative for two consecutive months. Two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture at the end of therapy.

- **Resistant to more than one drug but susceptible to isoniazid or rifampicin** (drug resistant but not MDR TB): two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy until cultures are negative for two consecutive months. Two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture at the end of therapy.

- **MDR TB** (resistant at least to both isoniazid and rifampicin): two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture once a month during therapy. Two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture at the end of therapy.

- **No drug susceptibility testing results** (culture negative): one sputum specimen should be collected and submitted for AFB microscopy and mycobacteria culture once a month during the entire course of therapy. Two sputum specimens should be collected and submitted for AFB microscopy and mycobacteria culture at the end of therapy.

Panel Physicians who are not providing TB care directly must continue to monitor clients throughout their treatment at least monthly. Where this treatment is undertaken with external providers, Panel Physicians should foster close ties with treating doctors and liaise regularly so as to identify / resolve problem issues that may arise. It is recommended that Panel Physicians provide written guidance to treating doctors to overview the requirements of treatment supervision required:

- minimum baseline investigations recommended (if not already performed)
- minimum treatment monitoring requirements
events that require notification to Panel Physician

minimum content of treatment certificate.

Treatment completion and certification

Treatment for active TB is defined as complete when the total number of doses has been administered, rather than when a defined period of time has expired. 2HREZ/4HR translates to a minimum of 182 doses of INH and RIF and 56 doses of PZA and EMB. If these are administered on a daily basis, the course of treatment will last six months. Any non-daily dosing regimen or treatment interruption will require a treatment course that exceeds six months.

Where treatment is undertaken by Panel Physician, upon completion of treatment:

- clinically review patient
- obtain post-treatment chest X-ray and compare with previous film/s
- finalise all forms
- submit completed file, treatment certificate and summary forms in eMedical.

Where treatment is undertaken through external provider, upon receipt of treatment certificate from external provider:

- review drug dosing and sputum test results
- arrange for post-treatment sputum collection x 2 (if this has not already occurred)
- arrange for post-treatment chest X-ray (if this has not already occurred)
- review X-ray series
- clinically review patient if concerns arise about X-ray stability or sputum results
- submit completed file and treatment certificate in eMedical.

47 Contact Tracing

Index case

For immigration medical purposes, where there is a confirmed case of TB identified, tracing of contacts, who are also applicants of the immigration service, must be undertaken.

Contacts of persons with pulmonary TB disease should be removed from exposure to the person with TB.

Which contacts should be traced

Contacts are defined as those with intimate or prolonged contact with the known index case, who have shared the same enclosed air space or other enclosed environment for a prolonged period and are likely to include family or household members.

Notification of relevant authorities

It is the responsibility of the Panel Physicians to notify and co-ordinate with local health authorities, where applicable, of a positive TB result.

Panel Physician responsibilities

Panel Physicians should do household contact tracing or, if the relevant health authority carries this out, confirm contact tracing activity has been undertaken.

Contact tracing in the immigration setting should be focused on contact with other visa applicants that fall into the contacts definition. For visa applicants, it is the responsibility of the Panel Physician to undertake contact tracing. One of the first activities is to review latest CXRs (if available).
Further evaluation

Further investigations on contacts include TST or IGRA.

If TST or IGRA are confirmed positive in close contacts, then the contact should be further evaluated. This would include a medical history, physical examination (Symptom check), and CXR if not already undertaken. If TST or IGRA are confirmed negative, then this test should be repeated in eight weeks’ time after exposure ends to ensure no conversion.

Contacts with clinical findings or a CXR suggestive of TB should provide three sputum specimens to undergo microscopy for AFB and culture for mycobacterium. Sections 2 ‘Screening’ and 3 ‘Laboratory Diagnostic tools’ of these Instructions provide greater information and guidance on the processes to be followed.

The following diagram shows the decision process for evaluating contacts of confirmed TB cases. Where a case of TB is confirmed, then the relevant health authorities are required to be informed, and the confirmed case placed on the appropriate pathway. Please note that in further evaluating people aged 11 years and older, lateral chest x-ray is not required.

Latent TB Infection (LTBI)

LTBI is a condition where a person is infected with Mycobacterium tuberculosis but does not have active TB disease. Screening for LTBI is undertaken with intent to treat if this diagnosis is made. In general in the migration setting this should occur after the client arrives in Australia and not be initiated.
by Panel Physicians. However if the client decides to undergo LTBI treatment, this can be initiated in the country of origin, but the client should understand that this treatment cannot be discontinued or interrupted once started, unless directed otherwise by the treating physician. Upon arrival in Australia, the client will need to present all medical reports and proof of treatment to a chest clinic in Australia. This will be arranged through the health undertaking process.

There are some specific exceptions where treatment of LTBI should be initiated in the client’s home country include:

- children who are immunocompromised
- children under the age of five years who are known to be close household contacts of a case of pulmonary TB where drug resistance has not been identified
- where there are expected to be lengthy delays prior to migration.

For an asymptomatic person found to have LTBI through positive TST or IGRA in a setting consistent with likely TB exposure, a number of regimens are available. Mono-therapy is used as standard treatment for LTBI within receiving countries due to the increased risk of toxicity associated with drug poly-therapy. These are:

- six to nine months isoniazid
- four months rifampicin.

The choice of above will depend on the resistance pattern of the index case if known. INH mono-therapy is advised if pan-susceptible infection is suspected.

Shorter regimens (for example, three months INH + Rifapentine or INH + Rif) are recommended in situations where patient compliance or availability factors might be expected to impact longer-course treatment.

48 Notification

Notification of local public health authorities

When an active TB case is found during the IME, Panel Physicians should communicate with the local public health authority as directed by their jurisdiction. The intents behind this practice are to:

- comply with the requirement of their respective jurisdiction so that contact tracing (and other public health related activities) can be initiated for those who would not be placed under the care of the Panel Physician
- engage early and work in close collaboration so that the plan of care is optimised
- ensure there is close follow-up and adherence to treatment/treatment failure
- enhance the communication between all parties so that failure to treat or adherence failure can be communicated sooner, rather than later, to DIBP
- improve notification and reporting rates within the National TB Programme.

Notification to the Department

Panel Physicians should report all cases of drug resistant-TB to Immigration Health (health@border.gov.au) within three working days of receipt of the DST report (whether multi, mono-, or poly- drug resistant-TB). For New Zealand cases this should be reported to Immigration New Zealand (inz-healthSupport@mbie.govt.nz).

In the special case when Panel Physicians manage MDR cases, they are to inform the applicant that upon arrival in Australia a medical follow-up will be required. This is regardless of knowing the final admissibility decision. Since the risk of reactivation remains high for MDR cases, this information is important.
Post-arrival medical follow up

Panel Physicians are responsible for gathering all the necessary information and submitting it so that a decision of admissibility can be made. Panel Physicians should introduce the notion of a mandatory medical follow-up to the applicant if/when their visa application is approved. Once the decision is rendered and admissibility is granted, the client will be advised of the requirements and the Department has protocols in place for notifying the appropriate public health authority upon the arrival of the individual.
Part E: Information for eMedical Enabled Clinics

49 What is eMedical?

eMedical is an electronic processing system that is used by clinic staff and Panel Members to record the results of immigration medical examinations, and submit the results to the Department. eMedical is currently used by the Australian Department of Immigration and Border Protection, Immigration Refugees and Citizenship Canada (IRCC), and Immigration New Zealand (INZ).

Australia, New Zealand and Canada aim to achieve 100 per cent electronic processing of all immigration medical examinations globally. Consequently, all members of their respective panel networks will be expected to use the system where technically possible. Using the available electronic processing technology will become a key requirement in terms of continuing as a member of the Australian Panel.

Further general information about the eMedical system and electronic processing is available on the Department’s website:

See: [http://www.border.gov.au/Busi/Pane/Pane/Online-health-(eMedical)](http://www.border.gov.au/Busi/Pane/Pane/Online-health-(eMedical))

Non-eMedical enabled clinics with questions relating to the technical requirements or implementation should contact Immigration Health.

User Guide and reference material

Detailed information on the use of eMedical is contained in the eMedical User Guide and associated tip sheets and quick reference guides. This information is provided as part of the training package to panel clinics and is updated regularly. The most recent versions of these documents are available via the ‘support page’ in the eMedical system itself.

eMedical support

All eMedical enquiries should be submitted via the ‘Contact Us’ tab in eMedical. Use the Panel Physician Enquiry form on the Department’s website if you are unable to access eMedical.


Locating clients in eMedical

It is recommended that you search for clients in eMedical at the time of arranging an appointment to ensure that there are no problems accessing their case in eMedical before they arrive at your clinic. Important: If you do this, you should not manage the client’s case until they arrive at your clinic for their appointment; otherwise you may lock their case to your clinic.

Australian visa applicants should be asked if they have a HAP ID. If your clinic is eMedical enabled and the applicant does not have documentation from the Department containing a HAP ID, ask if they have made a visa application. If so, the applicant should check their documentation from the Department or contact their visa processing officer/centre to confirm their HAP ID.

If the person has not yet lodged a visa application and intends to undertake their immigration medical examination before visa lodgement, they need to complete ‘My Health Declarations’ on the Department’s website after which they will be issued with a HAP ID.

More information about the process and links to ‘My Health Declarations’ can be found on the Department’s website.


More information about electronic processing for visa applicants and Panel clinics can be found on the Department’s website.

Confirmation of case submission in eMedical

Following completion and submission of a case in eMedical, panel clinics can generate an Information Sheet for clients to confirm submission. The Information Sheet can be printed or saved as a PDF and emailed.

Applicants with enquiries about the progress of their case or visa process must be referred to their visa processing centre/officer.

As per section 16 of these Instructions, applicants can be provided a copy of their case following submission on request. Clinics can use the ‘Print Health Case’ function to generate a copy to print or save as a PDF and email.
Appendix A: Psycho-Social Management for TB Patients

A diagnosis of TB carries with it a risk of negative psycho-social responses related to fears about the condition, the impact it may have on external perceptions of the client by others, the effects it may have on resettlement, and the difficulties that treatment may present. This can be particularly so for persons who are asymptomatic and have no known prior contact with TB. It is commonly perceived that people with TB become sick, so those that are not sick can resist the diagnosis. TB is also associated with lower socio-economic groups, meaning diagnosis may be further resisted in cohorts drawn from higher socio-economic strata.

Addressing the psycho-social impacts of TB diagnosis and treatment forms an important part of TB management.

In particular, clients may be concerned that:

- their health is at risk
- the health of their family is at risk
- their productivity or livelihood may be compromised
- they may be perceived negatively by others
- travel may be delayed
- they and their family may be rejected by the receiving country
- they may be separated from their family
- they may suffer adverse effects from treatment.

Support at diagnosis

Counselling should be provided to all persons identified as requiring TB treatment as indicated above. It should be explained that a diagnosis of TB will lead to travel delay but will not lead to rejection by the receiving country unless they refuse treatment. A family member or friend should be identified to assist and support the patient during treatment and observe for physical or psychological deterioration. To improve well-being, addressing diet or substance abuse should be promoted.

The psychological response to the need for treatment should be documented by the counsellor. Any person with significant negative responses beyond the ability of the counsellor to address should be brought to the attention of the physician. Any person with known psychological or psychiatric issues should also be brought to attention and psychiatric evaluation arranged if possible.

Any person requiring isolation should have the need for this clearly explained and reassurance given that this is only a temporary measure. A senior physician should be assigned as case manager for all isolation and MDR cases.

During Treatment

DOT providers (who should be trained health care workers such as nurses) should be observant for any signs of physical or psychological deterioration at the point of care. Brief questioning regards psychological status should form part of weekly side-effect monitoring. Any signs of psychological deterioration or psychiatric symptoms should be promptly brought to the attention of a supervisor or physician. Monthly physician review should include an evaluation of the patient’s mental state.

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2 Acknowledgement is provided to International Organization for Migration on whose guidelines Appendix A and B have been adapted.
Counselling should be made available on a weekly basis to all clients who wish to utilise this service. Counselling should address patients’ thoughts and feelings about their TB diagnosis and treatment; perceptions of stigma by others, and factors that may affect their adherence to treatment.

Alternative providers of psycho-social support (such as NGOs in refugee camps) should be enlisted to contribute to collaborative care where possible. Home visits may assist in holistic care where feasible.

Patients with MDR or in prolonged isolation for other reasons must be monitored very closely given their higher risk of negative psycho-social outcomes. This is additionally important with patients taking Cycloserine as depression and psychosis are known side-effects. All patients in isolation should be reviewed by a physician at least weekly. Isolation should be discontinued as soon as public health management needs allow, and should not be prolonged for other reasons.

Diversionary activities should be provided as much as possible to patients in prolonged isolation and family visits managed in order to ensure ongoing contact without unnecessary cross-infection risk. Patients in prolonged isolation should be encouraged to help support each other through treatment.

Multi-disciplinary staff meetings regarding TB cases should occur monthly, including nurses, psychosocial support team, psychiatrist, TB case managers, Panel Physicians and support staff as necessary. Overall patient care (including other relevant medical conditions) should be discussed in entirety during these meetings, including a review of patient mental state and psycho-social management and consideration of relevant family members. The importance of team effort, information sharing and coordination among staff caring for TB patients should be continuously highlighted.

Emphasis should be made on increasing capacity of staff to monitor overall patient condition, including recognizing mental changes and warning signs. Personnel should understand the need to listen and respond to individual patient needs rather than limiting interactions to purely medical information.
Appendix B: TB Infection Control

Minimisation of the risk of cross-infection of TB between infected persons, other clients and staff requires:

- awareness of transmission and the need for infection control
- adequate ventilation in all client use areas
- management of infectious patients
- personal protective equipment (PPE) for staff
- correct waste disposal.

Awareness of transmission and infection control

Educational material on TB infection control should be available for all staff and patients, with signage available in appropriate languages to inform people of the need for infection control. Information about “cough etiquette” should be displayed with tissues and masks made available in case of cough. Clients should be routinely asked about cough on entering the facility. Clients who are coughing should be provided with masks, separated from general client flows and prioritized for medical attention.

All TB patients and their support person should be educated in the means of transmission and methods of prevention.

All relevant staff should be trained in TB infection control and understand the mechanisms of transmission and prevention. An infection control staff member or group should be designated at each site to oversee infection control measures.

Adequate ventilation

Two basic principles govern infection prevention by ventilation:

- Air exchange refers to replacement of contaminated air by clean air.
- Air mixing refers to distribution of contaminated and clean air within a space equally so that overall concentrations of infectious particles are reduced.

TB laboratories have sophisticated ventilation systems that produce constant air change based on negative pressure within the lab. This is also utilised in sputum collection booths but is not feasible in general client use areas.

An ideal ventilation arrangement for such areas has components of both exchange and mixing using natural or low-tech solutions. Outdoor settings or rooms open to the outdoors allow air exchange to naturally occur, with air mixing also occurring naturally if breeze is present. Signage should be in place to prevent people from inadvertently closing doors or windows that need to be open for ventilation.

Mechanical devices such as standing electrical fans can be used to ensure air mixing in still air environments, whilst extractor fans can increase air exchange. Ideally, air flow should be directed from low to high concentrations of infectious particles. Where possible, staff should position themselves upwind from patients when working.

UV lights can also be used for cleaning air and surfaces, but these cannot be operated whilst staff or patients are in the same room unless the lights are directionally shielded. UV lights are not a substitute for more traditional cleaning methods, but they can provide a useful infection control supplement at relatively small cost.
Management of infectious patients

All patients known or suspected to be infectious (including those with high suspicion on the basis of X-ray results prior to sputum collection) should be provided with surgical masks, shown how to correctly fit these, and educated about the importance of wearing masks until they become non-infectious.

These patients should be managed away from general client flow areas, and never crowded into areas such as hallways or waiting rooms with other non-infectious persons. Sputum collection should occur in a segregated area, as should provision of DOT.

Prompt initiation of DOT is an important infection control measure as it reduces the duration of infectivity of the index case. The designated infection control officer should maintain or supervise the maintenance of a log of all TB suspects, referrals, and sputum smear results so that all infectious or potentially infectious patients are tracked.

A tracking system to measure patient time within the facility and time before DOT commencement should also be in place and monitored by the infection control officer.

Personal protective equipment

Staff working with infectious patients should wear N95 or equivalent masks at all times whilst in areas of potential exposure. Staff should be instructed in correct mask fitting and should not have facial hair which might compromise mask fit. Masks should be replaced regularly, and immediately if wet or damaged.

Gloves should be worn by staff handling infectious or potentially infectious materials including used tissues or facemasks.

Staff exposed to infectious or potentially infectious patients should have access to regular (at least annual) evaluations for TB exposure with a log kept of any TB cases that arise among staff.

Correct waste disposal

All contaminated materials relating to TB suspects or patients must be immediately disposed of into clearly-marked containers with biohazard signage. This includes used tissues, face-masks, and cups used for rinsing prior to sputum collection. This waste must be incinerated either onsite or offsite by a long-term waste contractor. If incineration occurs offsite, the designated infection control officer should inspect the site and review the disposal process at least annually.
Appendix C: Children (Aged 2 to 10 years) TB screening algorithm

1. TST
   - < 10 mm: Grade A
   - ≥ 10 mm: CXR (PA and lateral) 502 & 510
     - ≥ 5 mm in close household contacts: 719 TB Test
       - Positive: Abnormal
       - Indeterminate: Repeat test not required - Grade B with comment
       - Negative: Grade A
   - Normal: Grade B – with comment

2. 719 TB Test
   - Positive: Sputum Testing and refer to pulmonologist or paediatrician, sputum testing / gastric aspirate
   - Not consistent with TB and no clinical findings: Refer paediatrician review

3. IGRA
   - Indeterminate: Examine for consistent with TB and clinical findings OR strong suspicion of active TB
   - Negative: Grade A
   - Consistent with TB and clinical findings OR strong suspicion of active TB: Grade B – and comment

If positive for TB: TREAT
If negative: TREAT
Appendix D: Locations with Approved TB Facilities

All Panel Members in the specified locations must use the designated TB laboratory for sputum testing and other TB investigation. If TB treatment is offered by the facility that is host to the laboratory, this facility should be used as first choice for provision of DOT. This list is under development and Panel Members will be advised of updates or changes for their country. Please contact Immigration Health with any questions or further details.

<table>
<thead>
<tr>
<th>Country</th>
<th>City</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dhaka</td>
<td>IOM Dhaka</td>
</tr>
<tr>
<td></td>
<td>Beijing</td>
<td>Beijing ITHC</td>
</tr>
<tr>
<td></td>
<td>Chengdu</td>
<td>Western Hospital</td>
</tr>
<tr>
<td></td>
<td>Fuzhou</td>
<td>Fujian Provincial Hospital</td>
</tr>
<tr>
<td></td>
<td>Guangzhou</td>
<td>Guangdong ITHC</td>
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<tr>
<td></td>
<td>Jinan</td>
<td>Second Hospital of Shandong University</td>
</tr>
<tr>
<td></td>
<td>Shanghai</td>
<td>Shanghai ITHC</td>
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<tr>
<td></td>
<td>Shenzhen</td>
<td>202 Military Hospital</td>
</tr>
<tr>
<td></td>
<td>Wuhan</td>
<td>Wuhan TB Hospital</td>
</tr>
<tr>
<td>China</td>
<td></td>
<td></td>
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<tr>
<td>Egypt</td>
<td>Cairo</td>
<td>El Sadr TB Hospital</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Addis Ababa</td>
<td>International Clinical Laboratory</td>
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<tr>
<td></td>
<td>Ahmedabad</td>
<td>Apollo Hospital (near the airport)</td>
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<tr>
<td></td>
<td>Bangalore</td>
<td>SRL Diagnostics</td>
</tr>
<tr>
<td></td>
<td>Chandigarh</td>
<td>SRL Chandigarh</td>
</tr>
<tr>
<td></td>
<td>Chennai</td>
<td>Apollo Heart Centre</td>
</tr>
<tr>
<td></td>
<td>Hyderabad</td>
<td>Vijaya Diagnostics</td>
</tr>
<tr>
<td></td>
<td>Kolkata</td>
<td>SRL Religare</td>
</tr>
<tr>
<td></td>
<td>Ludhiana</td>
<td>SRL Ludhiana</td>
</tr>
<tr>
<td></td>
<td>New Delhi</td>
<td>SRL Gurgaon</td>
</tr>
<tr>
<td></td>
<td>Mumbai</td>
<td>Lilavati Hospital</td>
</tr>
<tr>
<td></td>
<td>Surat</td>
<td>Apollo Hospital</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Denpasar</td>
<td>Sanglah Hospital</td>
</tr>
<tr>
<td></td>
<td>Jakarta</td>
<td>Fakultas Kedokteran Universitas Indonesia (FKUI aka Micro-UI) or Persahabatan Hospital Laboratories</td>
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<td></td>
<td>Makassar</td>
<td>NHCR Hasanuddin University Medical Research Center</td>
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<tr>
<td></td>
<td>Medan</td>
<td>RS Adam Malik (Government Hospital)</td>
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<td>Semarang</td>
<td>BalaiLaboratoriumKesehatan</td>
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<td></td>
<td>Surabaya</td>
<td>BalaiBesarLaboratoriumKesehatan (BBLK)</td>
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<td>Kenya</td>
<td>Nairobi</td>
<td>IOM Nairobi</td>
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<td>Malaysia</td>
<td>Kuala Lumpur</td>
<td>IOM Kuala Lumpur</td>
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<tr>
<td>Nepal</td>
<td>Kathmandu</td>
<td>IOM Kathmandu</td>
</tr>
<tr>
<td>Philippines</td>
<td>Manila &amp; Baguio</td>
<td>St Luke’s Extension Clinic</td>
</tr>
<tr>
<td>Country</td>
<td>City</td>
<td>Clinic</td>
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<tr>
<td>Sri Lanka</td>
<td>All locations</td>
<td>Asiri Surgical Hospital</td>
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<td>Thailand</td>
<td>Bangkok</td>
<td>IOM Bangkok</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>Dili</td>
<td>Stamford Clinic</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Ho Chi Min</td>
<td>Cho Ray Hospital</td>
</tr>
<tr>
<td></td>
<td>Hanoi</td>
<td>IOM Hanoi</td>
</tr>
</tbody>
</table>
Appendix E: Undressing for a Medical Examination

For your medical examination you may need to take off all of your clothes but please keep your underwear on.

Please also remove your shoes and socks.
## Appendix F: Guidelines for Specific Medical Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Approach</th>
</tr>
</thead>
</table>
| Arthritis                     | ‘A’ Grade: Minor disease - no interference with function.  
'B' Grade: Significant disease affecting ADLs or work capacity or requiring management with disease modifying anti-rheumatic drugs (DMARDs), or likely to require surgery in the near future.  
Perform functional assessment and document treatment requirements.  
Specialist report not required unless requested. |
| Back pain                     | ‘A’ Grade: No functional impairment.  
'B' Grade: ADL’s and/or work capacity impaired. Perform functional assessment and provide treatment details. |
| BMI – body mass index         | ‘A’ Grade: Stable weight, or obesity without complications  
'B' Grade: Unexplained weight loss, or obesity with complications known or suspected. Provide details, relevant test results, and estimation of treatment needs. |
| Cancer                        | ‘A’ Grade: No recurrence ≥ five years post -treatment.  
'B' Grade: New diagnosis, recurrence exists, or if < five years since treatment. Recent specialist report required. |
| Cardiac murmur                | ‘A’ Grade: Asymptomatic, healthy applicant with normal X-ray where pathology has been excluded.  
'B' Grade: Symptomatic or evidence of cardiac failure. Cardiology opinion and echocardiography required. |
| Chest X-ray changes           | ‘A’ Grade: Anatomical variations and benign changes as per 6.  
'B' Grade: All pathological, infectious, or post-infectious changes. |
| Diabetes                      | ‘A’ Grade: If stable with no suspicion of end-organ damage.  
'B' Grade: End-organ complications known or suspected, especially renal impairment and peripheral neuropathy or vascular changes. Provide relevant investigation results. Specialist report not required unless requested. |
| Frail elderly                 | ‘A’ Grade: Reasonably fit with no cognitive or functional impairment.  
'B' Grade: Evidence of cognitive or functional impairment. ADL assessment/MMSE required. Document medical issues and treatment needs. |
| Hearing loss                  | ‘A’ Grade: Reasonable hearing with or without hearing aids.  
'B' Grade: Hearing loss affects daily function and is uncorrected by hearing aids. Obtain specialist report for children and young adults including comment on whether cochlear implant may be required. |
| Hepatitis B Surface antigen positive | ‘B’ Grade in all cases: Perform LFT’s and Hepatitis C test.  
Complications or abnormal liver function test results require gastroenterology assessment including ultrasound and/or fibroscan. |

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Note: ADLs = Activities of Daily Living. DMARDs = Disease Modifying Anti-Rheumatic Drugs. LFT = Liver Function Tests. MMSE = Mini-Mental State Examination.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C positive</td>
<td>‘B’ Grade in all cases: Perform LFT’s and Hepatitis B and HIV test. Complications or abnormal liver function test results require gastroenterology assessment including ultrasound and/or fibroscan.</td>
</tr>
<tr>
<td>HIV seropositive</td>
<td>‘B’ Grade in all cases once confirmatory assay result is available. If on treatment, request report from treating specialist and perform Hepatitis C test. If not treated, obtain CD4 count (if available) and specialist physician review.</td>
</tr>
<tr>
<td>Hypertension</td>
<td>‘A’ Grade: Stable with no evidence of end-organ involvement. ‘B’ Grade: Unstable and/or end-organ involvement suspected. Repeat BP &gt;160 systolic and/or diastolic &gt;100. Serum creatinine required. If raised, specialist report required.</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>‘A’ Grade: Stable and asymptomatic. ‘B’ Grade: If unstable or symptomatic, refer for cardiology assessment including echo.</td>
</tr>
<tr>
<td>Latent TB Infection</td>
<td>‘A’ Grade: TST &lt; 10mm or IGRA negative. ‘B’ Grade: TST &gt; 10mm, IGRA positive or indeterminate All close household contacts no matter the result of LTBI test.</td>
</tr>
<tr>
<td>Neurological disorders (for example, MS)</td>
<td>A Grade: Minor sequelae of previous disease (for example, deformity from childhood polio) B Grade: all significant and/or progressive neurological diagnoses, (for example MS, inherited disorders, cerebrovascular disease) See also ‘Physical disability’ below.</td>
</tr>
<tr>
<td>Obesity</td>
<td>See ‘BMI’ on previous page.</td>
</tr>
<tr>
<td>Physical disability</td>
<td>‘A’ Grade: Mild, without restriction on daily living or employment capacity. ‘B’ Grade: Significant disability impacting daily living or employment capacity. Perform functional assessment, including employment history if working age. Specialist report not required unless requested.</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>HBsAg testing is required if the applicant is intending to deliver in Australia. ‘A’ Grade: X-ray is available and normal, or client is from lower risk country ‘B’ Grade: No X-ray is available in clients from higher risk countries</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>‘A’ Grade: Skin involvement only ‘B’ Grade: Systemic complications such as arthritis are known or suspected.</td>
</tr>
<tr>
<td>Surgical history</td>
<td>‘A’ Grade: If past surgery has no effect on current health or function. Scars should not be recorded ‘B’ Grade: If past surgery impacts current health or function.</td>
</tr>
<tr>
<td>Condition</td>
<td>Approach</td>
</tr>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>TB – active disease</td>
<td>‘B’ Grade in all cases: Refer applicant for sputum collection and specialist assessment. Obtain HIV result if not already performed.</td>
</tr>
<tr>
<td>TB – no evidence of active disease</td>
<td>‘B’ Grade in all cases: Submit medical file without sputum collection.</td>
</tr>
</tbody>
</table>
| Thyroid                               | ‘A’ Grade: All benign thyroid disorders  
 ‘B’ Grade: If malignancy known or suspected. In that case, further investigation such as an ultrasound and/or specialist report required. |
| Urine abnormalities                   | The grade will be auto-managed by eMedical. For paper cases:  
 ‘A’ Grade: repeat urinalysis is normal and/or red cells less than 10 per hpf (microscopy), or isolated glycosuria with no other evidence of end-organ disease.  
 ‘B’ Grade: all other urinary abnormalities. |
| Visual impairment                     | ‘A’ Grade: VA > 6/24 in better eye.  
 ‘B’ Grade: If VA ≤ 6/24 in better eye, eMedical will auto ‘B’ grade. Add comment on functional capacity, but specialist report not required unless requested. |
Appendix G: Child Development Milestone Guidelines

This is one of the most difficult parts of any examination, especially if you have never met the child before and the child is anxious. Much can be achieved by observing the child, talking to the parents/guardians and having the child perform some simple tasks. It is especially important to have a high index of suspicion of developmental problems in adoption cases.

The following are average ages for the milestones.

<table>
<thead>
<tr>
<th>Gross Motor</th>
<th>Milestones Given</th>
<th>Cognitive</th>
<th>Milestones Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chin up</td>
<td>1 month</td>
<td>Shows anticipatory excitement</td>
<td>3 months</td>
</tr>
<tr>
<td>Lifts head</td>
<td>4 months</td>
<td>Plays with rattle</td>
<td>4 months</td>
</tr>
<tr>
<td>Rolls - prone to supine</td>
<td>4 months</td>
<td>Plays peek-a-boo</td>
<td>8 months</td>
</tr>
<tr>
<td>Rolls - supine to prone</td>
<td>5 months</td>
<td>Finds hidden object</td>
<td>9 months</td>
</tr>
<tr>
<td>Sits unsupported</td>
<td>8 months</td>
<td>Pulls string to obtain toy</td>
<td>14 months</td>
</tr>
<tr>
<td>Pulls to stand</td>
<td>9 months</td>
<td>Activates mechanical toy</td>
<td>20 months</td>
</tr>
<tr>
<td>Cruises</td>
<td>10 months</td>
<td>Pretend play</td>
<td>24 months</td>
</tr>
<tr>
<td>Walks alone</td>
<td>13 months</td>
<td>Seeks out others for play</td>
<td>36 months</td>
</tr>
<tr>
<td>Walks up stairs</td>
<td>20 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rides tricycle</td>
<td>36 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hops on one foot</td>
<td>60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fine Motor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unfisting</td>
<td>3 months</td>
<td>Da-da - inappropriate</td>
<td>8 months</td>
</tr>
<tr>
<td>Reach and grasp</td>
<td>5 months</td>
<td>Da/Ma - appropriate</td>
<td>10 months</td>
</tr>
<tr>
<td>Transfer</td>
<td>6 months</td>
<td>First word</td>
<td>11 months</td>
</tr>
<tr>
<td>Thumb-finger grasp</td>
<td>9 months</td>
<td>Two to six words</td>
<td>15 months</td>
</tr>
<tr>
<td>Tower of two cubes</td>
<td>16 months</td>
<td>Two-word phrases</td>
<td>21 months</td>
</tr>
<tr>
<td>Handedness</td>
<td>24 months</td>
<td>Speech all understandable</td>
<td>27 months</td>
</tr>
<tr>
<td>Scribbles</td>
<td>24 months</td>
<td>Names one colour</td>
<td>30 months</td>
</tr>
<tr>
<td>Tower of four cubes</td>
<td>26 months</td>
<td>Uses plurals</td>
<td>36 months</td>
</tr>
<tr>
<td>Tower of eight cubes</td>
<td>40 months</td>
<td>Names four colours</td>
<td>42 months</td>
</tr>
<tr>
<td>Social/Self Help</td>
<td></td>
<td>Gives first and last names</td>
<td>44 months</td>
</tr>
<tr>
<td>Social smile</td>
<td>6 weeks</td>
<td>Names two opposites</td>
<td>50 months</td>
</tr>
<tr>
<td>Recognises mother</td>
<td>3 months</td>
<td>Strings sentences together</td>
<td>60 months</td>
</tr>
<tr>
<td>Stranger anxiety</td>
<td>9 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finger feeds</td>
<td>10 months</td>
<td>Receptive Language</td>
<td></td>
</tr>
<tr>
<td>Uses spoon</td>
<td>15 months</td>
<td>Gesture games</td>
<td>9 months</td>
</tr>
<tr>
<td>Uses fork</td>
<td>21 months</td>
<td>Understands ‘no’</td>
<td>9 months</td>
</tr>
<tr>
<td>Assists with dressing</td>
<td>12 months</td>
<td>Follows one-step command</td>
<td>12 months</td>
</tr>
<tr>
<td>Pulls off socks</td>
<td>15 months</td>
<td>Points to animal pictures</td>
<td>19 months</td>
</tr>
<tr>
<td>Unbuttons</td>
<td>30 months</td>
<td>Points to six body parts</td>
<td>20 months</td>
</tr>
<tr>
<td>Buttons</td>
<td>48 months</td>
<td>Follows two-step command</td>
<td>24 months</td>
</tr>
<tr>
<td>Ties shoelaces</td>
<td>60 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dresses without supervision</td>
<td>60 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Appendix H: Activities of Daily Living (ADL) Assessment (903)

<table>
<thead>
<tr>
<th>Applicant’s Name:</th>
<th>Applicant's DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-care</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intact</td>
</tr>
<tr>
<td><strong>Note performance without help</strong></td>
<td><strong>Note degree of assistance</strong></td>
</tr>
<tr>
<td>With ease, no devices or prior preparation</td>
<td>With difficulty or with devices or prior preparation</td>
</tr>
<tr>
<td><strong>Food/drink</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Dress upper body</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Dress lower body</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Puts on brace/prosthesis</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Wash/bathe</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Perineum (at toilet)</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Sphincters’ control</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Note control without help</strong></td>
<td><strong>Note frequency of accident</strong></td>
</tr>
<tr>
<td>Complete voluntary</td>
<td>Control but with urgency, or use of catheter, appliance</td>
</tr>
<tr>
<td><strong>Bladder control</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Bowel control</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Mobility/locomotion</strong></td>
<td>With ease, no devices or prior preparation</td>
</tr>
<tr>
<td><strong>Transfer bed</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Transfer</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Transfer toilet</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Transfer bath/shower</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Transfer car</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Walk 50 metres – level</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Stairs, up/down one floor</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Walk outdoors – 50</strong></td>
<td>☐</td>
</tr>
<tr>
<td><strong>Wheelchair – 50 metres</strong></td>
<td>☐</td>
</tr>
</tbody>
</table>

**NB:** In the context of the functional assessment, devices include such aids as feeding-cuffs, special cutlery dishes, dressing-aides, transfer boards/poles.

| Communication | ☐ | ☐ | ☐ | ☐ |
| Comprehension | ☐ | ☐ | ☐ | ☐ |
| Expression    | ☐ | ☐ | ☐ | ☐ |
| Social cognition | ☐ | ☐ | ☐ | ☐ |
| Social interaction | ☐ | ☐ | ☐ | ☐ |
| Memory        | ☐ | ☐ | ☐ | ☐ |

**Current residence**
- [ ] Own home
- [ ] Relative’s home
- [ ] Personal care
- [ ] Hospital
- [ ] Other (please specify)

**Time at above**
- Years: __________________________
- Months: __________________________

**Current Caregiver Designation:**

---

Printed name and signature of examining physician

Date (dd/mm/yyyy)
Appendix I: Examples of Insignificant Medical Conditions

Any condition which does not impact on functional capacity or long-term prognosis can be ‘A’ graded in all instances. Relevant fields in the 501 or 502 eMedical requirement should be marked normal, and the case ‘A’ graded. These findings can be added as general supporting comments next to the ‘A’ grading.

Such conditions include:

<table>
<thead>
<tr>
<th>Medical Findings</th>
<th>X-ray Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>Aortic calcification</td>
</tr>
<tr>
<td>Allergic rhinitis</td>
<td>Apical capping (with smooth border)</td>
</tr>
<tr>
<td>Asthma (controlled)</td>
<td>Atelectasis</td>
</tr>
<tr>
<td>Astigmatism (corrected)</td>
<td>Azygous fissure/lobe or other accessory fissures</td>
</tr>
<tr>
<td>Breast fibroadenoma</td>
<td>Breast implants</td>
</tr>
<tr>
<td>Dental disease</td>
<td>Cardiomegaly, mild (CTR &lt; 60%)</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>Dextrocardia</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
</tr>
<tr>
<td>Fibrocystic disease</td>
<td></td>
</tr>
<tr>
<td>Fibroids</td>
<td></td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
</tr>
<tr>
<td>HRT (hormone-replacement therapy)</td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td></td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td></td>
</tr>
<tr>
<td>Hypo/Hyper Thyroidism (uncomplicated)</td>
<td></td>
</tr>
<tr>
<td>Infertility</td>
<td>Nipple shadows</td>
</tr>
<tr>
<td>Keloids</td>
<td>Pectus excavatum</td>
</tr>
<tr>
<td>Lipoma</td>
<td>Raised hemi-diaphragm</td>
</tr>
<tr>
<td>Menopause</td>
<td>Rib abnormalities (for example cervical ribs,</td>
</tr>
<tr>
<td></td>
<td>previous rib fractures, bifid ribs, congenital rib</td>
</tr>
<tr>
<td></td>
<td>fusion)</td>
</tr>
<tr>
<td>Minor Surgery: Appendectomy, Caesarean section,</td>
<td></td>
</tr>
<tr>
<td>Cholecystectomy, cosmetic surgery, nasal operations</td>
<td></td>
</tr>
<tr>
<td>or corrections, Rhinoplasty, Tonsillectomy</td>
<td></td>
</tr>
<tr>
<td>Myopia</td>
<td></td>
</tr>
<tr>
<td>Otitis externa</td>
<td></td>
</tr>
<tr>
<td>Prostatic hypertrophy</td>
<td></td>
</tr>
<tr>
<td>Refractive errors of vision (for example, myopia)</td>
<td></td>
</tr>
<tr>
<td>Tattoos</td>
<td></td>
</tr>
<tr>
<td>Uterine fibroids (fibromyoma uteri)</td>
<td></td>
</tr>
<tr>
<td>Varicose-vein surgery</td>
<td></td>
</tr>
<tr>
<td>Vitiligo</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X-ray Findings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aortic calcification</td>
<td>Nipple shadows</td>
</tr>
<tr>
<td>Apical capping (with smooth border)</td>
<td>Pectus excavatum</td>
</tr>
<tr>
<td>Atelectasis</td>
<td>Raised hemi-diaphragm</td>
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<tr>
<td>Azygous fissure/lobe or other accessory fissures</td>
<td>Rib abnormalities (for example cervical ribs,</td>
</tr>
<tr>
<td></td>
<td>previous rib fractures, bifid ribs, congenital rib</td>
</tr>
<tr>
<td></td>
<td>fusion)</td>
</tr>
<tr>
<td>Breast implants</td>
<td></td>
</tr>
<tr>
<td>Cardiomegaly, mild (CTR &lt; 60%)</td>
<td></td>
</tr>
<tr>
<td>Dextrocardia</td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Undertaking to Operate within the Bounds of the Australian Panel Member Instructions

UNDERTAKING TO OPERATE WITHIN THE BOUNDS OF THE AUSTRALIAN PANEL MEMBER INSTRUCTIONS FOR CONDUCTING AUSTRALIAN IMMIGRATION MEDICAL EXAMINATIONS

I, ......................................................................................... (insert name) acknowledge as a result of requesting panel membership for conducting Australian Immigration Medical Examinations, I am not an employee of the Australian Federal Government.

I also confirm that I have received a copy of the ‘Panel Member Instructions’, and that I have familiarised myself with its content. Should I be offered panel membership, I accept that I will operate within the bounds of these Instructions.

I acknowledge that my work as a Panel Member will be audited periodically, and I agree to cooperate fully with all audit requirements. I understand that the ongoing membership of a Panel Member is contingent on the information obtained through the conduct of these audits.

I also understand that the Department of Immigration and Border Protection, a Department of the Australian Federal Government, can cancel or suspend my membership of the Panel at its discretion and may not enter into a review process.

I understand I have no legal expectation to work for the Australian Federal Government.

I confirm that I have no existing conflicts of interest which may affect my ability to work as a Panel Member and I will bring any conflicts of interest which may arise to the immediate attention of the Department.

Full name (in block letters):
.................................................................................................................................

(As per identity documentation provided)

Signature: .........................................................................................

Date: .........................................................................................