Australian Panel Member Instructions

Immigration Medical Examinations
July 2020
These Instructions are prepared in accordance with Australian laws and are for the benefit of the Australian Government. The Department of Home Affairs must be advised if any of these instructions contravene or appear to contravene any laws in the Panel country.
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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 Home Affairs (the Department) in conducting IMEs 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 Panel Members in these instructions.

The Panel Member Instructions (the Instructions) for Australian IMEs 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 IME requirements
- the standards of service and clinic facilities required.

The Panel Member Instructions are available in an electronic format on the Department’s website at:


These instructions are reviewed and updated periodically, however advice of updates or changes in the interim may be sent at any time to Panel Members. It is your responsibility to keep yourself informed of the latest version of the Instructions and any updates.

These Instructions do not provide technical advice relating to the use of eMedical. Panel Members should refer to the ‘eMedical Support’ tab for tip sheets and other supporting material.

1. Panel Management

The Department of Home Affairs

The Department manages the panel network around the world, including:

- managing the number and location of panel sites and Panel Members
- conducting audits to assess both quality and integrity of the work done by the network
- providing training
- responding to administrative queries from Panel Members
- communicating policy, procedural and clinical changes in respect of our health requirements
- addressing any case-specific enquiries
- issuing Instructions for Panel Members including in respect of their IME requirements
- addressing all eMedical system related queries.
Role of the Department’s offices outside of Australia

Although the Department 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:

- monitoring local health issues and trends
- monitoring Panel Member performance
- providing an alternative contact point for Panel Members in emergencies
- conducting clinic site visits.

2. How to Contact Us

You can contact the Department about any Australian immigration health matters.

All eMedical system and IME 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.


The PPE form can be used for the following queries:

- being unable to logon to eMedical, for example the system is unavailable and repeat logon attempts have failed
- 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 IMEs 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 applicant
- information for or approval required from the Department, for example, you need to advise us about a change in your clinic details or appoint a locum physician
- queries regarding membership of the Australian Panel Physician network
- staff who are eMedical enabled and cannot access eMedical
- 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 the Department 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 applicant’s HAP ID. Additional contact information is as follows:

Email: health@homeaffairs.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 Branch, Department of Home Affairs,
      GPO Box 9984, Sydney NSW 2001, Australia


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

Note: For general visa and migration related enquiries please refer to the Department’s website:
3. **Use of eMedical**

eMedical is an electronic processing system that is used by Panel clinic staff and Panel Members to record the results of IME and Departure Health Check, and submit the results to the Department. eMedical is currently used by the Australian Department of Home Affairs, Immigration New Zealand (INZ), Immigration Refugees and Citizenship Canada (IRCC) and United States of America (USA).

Australia, New Zealand, Canada and USA aim to achieve 100 per cent electronic processing of all IMEs 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 is 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: [https://www.homeaffairs.gov.au/Busi/Pane/Pane/Online-health-(eMedical)](https://www.homeaffairs.gov.au/Busi/Pane/Pane/Online-health-(eMedical))

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

**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 eMedical Support tab in the eMedical system itself.

**eMedical support**

All 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.


4. **Australia’s Immigration Medical Examination Process**

**The health requirement**

Applicants for Australian visas, and sometimes their non-migrating family members, need to meet the health requirement as 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:
The only medical condition that, in itself, prevents the grant of a visa as prescribed in the Migration Regulations 1994, is active TB. If an applicant is found to have active TB, they must demonstrate that they have satisfactorily completed a full course of treatment and an Australian Medical Officer of the Commonwealth (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 despite 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.


How to determine which examinations are required

Panel Members are not required to determine what examinations are required. Decisions about the required health examinations are made by the Department.

The examinations required for each applicant will depend on a number of factors. These are set out in the Migration Regulations 1994 and consideration is made of the following:

- type of visa
- intended length of stay and activities
- country of citizenship and residence during the previous five years
- age
- any medical issues the Australian Government considers as of special significance
- an Australian IME 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 IME.

For panel sites using eMedical:

The applicant should provide their HAP ID to the clinic which should be used to access their record in eMedical. The eMedical record of the applicant will list the examinations required based on the information provided by the applicant to the Department. In some cases, based on information provided by the applicant at the IME, the Panel Member may be required to add further examinations in accordance with the Instructions. If the applicant does not have a HAP ID, refer to the eMedical User Guide.

For panel sites not using eMedical:

The applicant should present a letter from the Department. This letter will provide a list of examinations required based on information provided by the applicant to the Department. Applicants should only be given appointments once they confirm possession of a HAP letter, and they should be reminded to bring this along to their IME appointment.

If you are concerned that the correct examination has not been requested, please contact us to clarify what is needed. Alternatively, the applicant can contact the Department, 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, provided they consent to it, should be examined in the first instance according to the requirements for permanent visa applicants.
Age milestones

The examinations required depend on the age of the applicant.

Applicants may transition age milestones during the visa process. In these circumstances, Panel Members are instructed to complete the examinations based on the age of the applicant at the time of the IME.

Examinations no longer required (such as the 719 TB test in children) should be finalised in eMedical as incomplete with a note explaining the reason.

Assessment of Immigration Medical Examinations

The Department is responsible for managing all components of IME processing for Australian health cases both in Australia and around the world.

Medical Officers of the Commonwealth (MOCs) employed by the Department’s contracted medical visa service provider are located in Australia and assess Australian health cases submitted by Panel Members from around the world to provide an opinion about whether applicants meet Australia’s immigration health requirement. Please note it is not the role of the Panel Member to provide an opinion or comment on whether the applicant may or may not meet the health requirement.

5. Panel Membership

Panel Members are not employees of the Australian Government and are empanelled at the absolute discretion of the Department. They do not represent the Australian Government and those located outside Australia do not have a contractual arrangement with the 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 the 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 if this occurs.

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

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 program
- applicants’ choices
- suspension or cessation of panel membership

Information in regard to the clinic facility must be provided to the Department. The decision to accept panel memberships is made by the Department in consideration of a number of factors including, but not limited to, caseload in the region, current panel presence, suitability of the physician and the panel site offered. The Department prefers sites that offer a ‘one-stop shop’ experience (medical, radiology, pathology and preferably TB investigation and treatment all at one location), digital radiology and internet service to support eMedical. The sites must also be laid out in a way that supports the integrity of the IME process. The suitability assessment of a new site may require a visit by the Department.

While membership is attached to the individual Panel Member, the Department considers 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 IME may be delegated to nursing or other staff, the Panel Member retains responsibility for the overall process.

The number of Panel Members at a panel site should be commensurate with an optimum caseload for each member to maintain a desired level of experience and expertise in conducting IMEs without compromising on quality and accuracy. The Department may, from time to time, request that panel sites review the number of Panel Members to ensure this is maintained.
New Panel Members at existing panel clinics should undergo an orientation program that should include familiarisation with the Instructions, observing other Panel Members conduct IMEs, conducting IMEs under supervision and be provided with ongoing mentoring by the experienced Panel Members at the panel site.

**Relocation of a Panel Member clinic**

Panel membership, while attached to the individual physician, is in association to a specific panel clinic. This means that unless confirmed by the Department, all memberships affiliated with the original panel clinic automatically ceases upon relocation of the clinic or when the Panel Member moves to another clinic. Any IME conducted by the Panel Members at a new location whilst their membership is not valid will not be accepted.

The Department is to be advised at least four weeks before the relocation of a clinic and if acceptable, the Department’s website will be updated accordingly and the local departmental office will be notified of the change. Panel clinics should provide as much detail about their operations at the new site as possible. It should include, but not be limited to, floor plans, photographs, proposed staffing or any other relevant detail. IME operations at the new site should only commence after clearance by the Department.

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

See: [https://www.homeaffairs.gov.au/Busi/Pane/Pane-1](https://www.homeaffairs.gov.au/Busi/Pane/Pane-1)

**Retirement or withdrawal of membership**

The Department 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**

If the Department is made aware of any potential or alleged breach of procedural integrity (including allegations of fraud), failure to meet performance standards, non-compliance with the Instructions or a breach of the Code of Conduct, Panel membership may be suspended until a complete investigation is conducted.

Suspension may occur in the following situations:

- the Panel Member appears to have 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.
- the Panel Member is under investigation by the local medical registration authority or law enforcement agency, regardless of the reason, until such an investigation is completed and a decision can be made by the Department on the status of the panel membership.
- The Panel Member is under investigation by an intergovernmental partner, regardless of the reason, until such an investigation is completed and a decision can be made by the Department on the status of the panel membership.

In such cases, the Panel Member will be provided with a written notice of suspension, including the reason for suspension and provided opportunity to respond. In cases where an allegation of misconduct is received, the identity of the complainant may not necessarily be disclosed to the Panel Member for privacy and confidentiality reasons.

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 Department before a decision is made as to whether the panel membership should continue.

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. Removal may also occur where the Panel Member brings into disrepute the Australian Government.

**Removal from the Panel**

Panel membership may be revoked at any time at the sole and absolute discretion of the Department. The decision to cease membership is final and not subject to review. The Department will usually provide four weeks’ notice before cessation takes effect. A shorter notification period may apply under some circumstances such as where the Panel Member is already subject to a suspension.

Panel Members may have their membership revoked on clinical grounds. 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 based on the Department’s consolidation strategies where there is a decreased need for Panel clinics in a particular region, increased capacity due to technological advancements, reduced client demands, alignment with intergovernmental partners or a change in policy. The Department will make reasonable efforts to give as much notice as possible of any intended changes to panel composition.

In the event the Department has made a decision to discontinue Panel operations at a Panel site, membership of all panel members at the site will cease.

**Use of accredited laboratories**

Blood and urine specimens should always be collected at the panel clinic at the time of the IME. Applicants should not be referred to a laboratory for this purpose. Sputum samples must be collected either at the panel clinic or at the laboratory (see section on Collection of Sputum in Part D and Appendix D).

Panel Physicians are responsible for the selection of suitably accredited laboratories to perform HIV and other serological testing. Panel Physicians should have confidence in the chosen laboratory’s security of samples, chain of custody for handling specimens in transport and in the laboratory, use of coding for specimens, in-date test-kits are used, and that applicants are never able to access their samples or coding information. With the exception of dipstick urinalysis and Tuberculin Skin Tests, original laboratory reports must be provided to the Department (either uploaded directly into eMedical or attached to the Form 26) directly by the panel clinic.

Laboratories used for processing pathology specimens must be involved in external quality assurance programs 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. Panel Physicians should identify and use high quality facilities suitable for this purpose and ensure specimens are processed according to these Instructions, and if necessary, in consultation with, or under guidance from the Department.

**The role of Panel Physicians**

Panel Physicians are expected to:

- personally carry out a complete and thorough medical (physical and mental) examination, impartially grade and submit the reports in accordance with the Instructions
- ensure the quality and integrity of the entire IME process
- provide accurate and complete reporting on the health of the applicant
- ensure selection of appropriate specialist service providers that meet our requirements
- ensure that specialist service providers, pathology laboratories and TB testing and treatment clinics have access to, and understand these Instructions, particularly the integrity requirements
- advise applicants of any abnormalities of clinical significance found during the examination
- keep applicants updated about the progress of the examinations, particularly when these are delayed for any reason
• refer applicants requiring treatment to their usual treating physician unless emergency treatment is required
• advise the Department of changes to the Panel Member’s and/or panel clinic’s contact details, operating hours, working arrangements, clinic closures and Panel Member’s leave arrangements (for absences longer than seven working days), and ensure continuity of IME services
• use eMedical as per terms and conditions of use
• comply with the Australian privacy and confidentiality provisions that apply to applicants’ personal (including health) information.

Panel Physicians are not:
• authorised to oversee IMEs conducted by non-Panel Members
• permitted to provide treatment to applicants except in emergencies or in relation to TB (see Part D of the Instructions)
• responsible for providing opinions or comments as to whether the applicants meet the health requirements (this is the role of the MOC)
• to hand over any original completed IME paper forms or medical reports/results to the applicants for submission to Department under any circumstances
• to give their eMedical account logon and password details to anyone else
• permitted to engage in business relating to immigration services (such as a Migration Agent).

The role of Chief Radiologist/Panel Radiologists

Every clinic that offers radiology services must have a Chief Radiologist who must be a Panel Member. The Chief Radiologist may nominate in writing any other radiologist for IME work, but the number of nominated radiologists should be limited to ensure that they have sufficient workload to maintain their experience and expertise in IME work. This ensures that the Department’s records of all medical examiners involved with the IME are maintained and radiologists receive access to eMedical where available.

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

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

Chief Radiologists are expected to:
• ensure that all nominated radiologists undertaking Australian immigration radiological examinations are suitably qualified and experienced as a specialist in radiology and are registered to work in their country of practice
• receive feedback about nominated radiologists and staff in their clinic and work with the relevant country/Panel managing country to resolve cases or issues of concern
• ensure that radiological examinations are conducted only at the approved site/s
• put into practice and monitor the procedures for checking identity of applicants
• circulate all communications from the Department to nominated radiologists and staff
• advise the Department of changes to staffing, clinic contact details, capabilities and working arrangements, including any changes to these including significant periods of in-operation such as absences longer than seven working days or cessation of employment

• add nominated radiologists to the clinic profile in eMedical and notify the Department of these so that access to submit Australian cases can be granted

• for paper cases, ensure that the X-ray examination forms and films are forwarded to the Panel Physician

• ensure that individual radiologists excluded from conducting Australian radiological examinations do not conduct radiological examinations and report/grade or submit them

• ensure the quality and integrity of the entire IME process.

Chief Radiologists and nominated radiologists are expected to:

• personally carry out a complete and thorough radiological examination, impartially grade and submit them in accordance with the Instructions

• ensure the quality of the radiographic images

• ensure that radiation safety equipment is used to protect the applicants and staff

• ensure that all pregnant applicants taking a chest X-ray are counselled about radiation risks and obtain necessary consent or verify that the risks have been explained to the applicant

• keep applicants updated about the progress of the examinations particularly when these are delayed for any reason

• conduct radiological examinations and report, grade and submit for applicants aged 11 years or older

• conduct radiological examinations for applicants younger aged 10 years and under who require further investigation of TB if referred by a Panel Physician

• provide accurate and complete reporting on the health status of applicants, determined by radiological examinations

• 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, for example, when active TB is suspected

• refer applicants requiring treatment, other than emergency treatment, to their usual treating physician

• use eMedical (where available) as per Terms and Conditions of use.

Chief Radiologists and nominated radiologists are not:

• responsible for providing opinions or comments as to whether the applicant meets the health requirement (this is the role of the MOC)

• to hand over any original completed IME paper forms or medical reports/results to the applicants for submission to Department under any circumstances

• to give their eMedical account logon and password details to anyone else

• permitted to engage in business relating to immigration services (such as a Migration Agent).

Use of locum physicians and radiologists

For locum Panel Member applications to cover leave or caseload surges, please contact the Department for further information.
For clinics with sole Panel Members, a minimum of four weeks’ notice should be provided to the Department for planned leave

**Medical registration**

Panel Members are required to be appropriately qualified and experienced noting that applicants’ health clearances are assessed according to Australian standards. Physicians trained exclusively in alternative medicine or complementary medicine (for example, Naturopathy or Traditional Chinese Medicine) are not suitable.

Panel Members must maintain professional registration and unconditional good standing with the 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 the Department.

If a Panel Member has been reported to their medical registration authority and/or is under investigation for any reason, they must inform the Department immediately in writing and cease undertaking any Australian IME until further notice.

If a Panel Member becomes de-registered or restricted in their country of practice, they must inform the Department immediately and cease undertaking any Australian IME.

Panel Members are required to provide evidence of their current registration or licence status during an onsite audit visit or upon request.

**Conflicts 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 actual, perceived or potential conflicts of interest must be fully disclosed to the Department as soon as it is identified.

Therefore, when conducting IMEs for Australian applicants, 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 seen to conflict with conducting IME
- consider if the commercial and professional relationships present an actual or perceived conflict of interest with their associated clinics and other third parties, such as migration agencies, and would impact on the independence and reliability of medical reports provided by the Panel Members
- notify the Department of the potential conflict of interest when the interests of their or their staff’s immediate family members are involved
- not use information obtained in the course of the IME work to gain, directly or indirectly, financial or other advantage for themselves or for any other person
- not be the treating physician of an applicant, or an applicant’s family member.

If a medical condition is identified during the course of the IME, the Panel Member should refer the applicant to an appropriate medical professional.

Panel Members must advise the Department of any instances where others may perceive that the Panel Member has a conflict of interest in performing Australian IME. Examples include conducting IMEs 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.

**Note:** Panel Members must not receive or accept services, incentive fees or gratuities of any kind that are intended to influence the impartiality or IME findings. If Panel Members accept any services, incentive fees or gratuities of this nature, the panel membership may be ceased.
Professional development

All Panel Members are expected to maintain currency of knowledge and have ongoing professional development and continuing medical education. 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 health specific training sessions and summits run by the Department, intergovernmental partners (USA, UK, Canada and New Zealand) or the International Panel Physicians Association (IPPA). Panel Members must complete any training instructed by the Department.

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 Australian health requirement. However, other conditions may become apparent during the examination and the Panel Member has a responsibility to ensure that the applicant is advised of this condition.

In all cases, the Panel Member must advise the applicant of any abnormal findings. It is not appropriate for the Panel Member to undertake any form of treatment, unless in emergency situation or in relation to TB, as outlined in Part D of the Instructions. The Panel Member’s role is that of an independent medical examiner who must provide the Department with an impartial opinion (see Conflict of interest above).

Communication with the Department

Panel Members are required to be able to communicate effectively in English. Panel Members must ensure that all reports are completed in English or translated into English by an accredited translator. Reports should clearly show the applicant’s name, date of birth, HAP ID and passport number, and if translation is required, the name and contact details of the person who translated the reports.

Panel Members and their staff must respond to departmental correspondence in a timely manner within the timeframe advised by the Department.

The Department’s preferred mode of contact by the panel network is through the ‘Contact Us’ tab in eMedical. Panel sites without eMedical can use the Panel Physician Enquiry (PPE) form available on our website.

Providing information to the applicant

The Department requires Panel Members to provide applicants with information about their services such as fees, clinic address, contact details, hours of operation, instructions on how to prepare for and what to expect at the IME, including advice that a full physical examination will be undertaken requiring them to undress to underwear. This includes advising them of the duration of the IME, what they should bring with them (for example, their valid original passport, previous medical records and glasses or contact lenses) and that women should be strongly encouraged to reschedule their IME if they are menstruating. The Department may ask for copies of any written information provided to applicants and it will usually be reviewed as part of an audit.

Note: Panel Members must not use the Australian 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 engaged by the Commonwealth of Australia or the Department as an employee or contractor.

Record keeping

eMedical creates an electronic record of all examinations once submitted. After submitting the case, Panel Members can still view cases they have completed by entering the electronic identification number (such as TRN or HAP ID) of the applicant in the eMedical search field. However, no changes can be made to the content, photo or grading after the case is submitted.

Clinics should keep a record of the applicants they have examined, along with their HAP ID, so that they can access the records after submission if required. This is useful both for internal quality assurance and if the applicant attends for a new IME. The Department does not require additional medical records to be maintained. eMedical records can be printed or saved electronically if required, for example, if the applicant 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 applicant has chosen to attend an alternate clinic to complete the examination.

Panel Members should ensure that the correct and complete information is recorded and attached in eMedical before submitting the health case. This includes ensuring that the correct photo, identity document information (including passport issue and expiry dates), chest X-ray and any reports are attached to the correct applicant in eMedical. Grading should also be verified before submitting the case.

If a health case was accidentally submitted in eMedical with incorrect or incomplete information, such as photos, reports or grading, the Panel Member must report this to the Department as soon as they become aware of this matter.

Panel Members should observe local regulations about medical recordkeeping.

For IMEs that are completed on paper forms, Panel Members should keep adequate records including the applicant's details and whether an ‘A’ or ‘B’ grading was given. Comprehensive notes and evidence should also be kept of any applicants where significant abnormalities or identity concerns were identified. These records should be kept for a period of at least 12 months.

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

For quality assurance purposes, clinics are encouraged to maintain data on a monthly basis on:

- caseload numbers (per Panel Member)
- ‘A’ and ‘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 their own medical records, this can and should be provided. In eMedical, this is best done through the ‘Print Health Case’ function. Applicants may also obtain a copy of specialist or pathology reports.

**Quality assurance**

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

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

In accepting panel membership, Panel Members agree to participate in such audits and reviews.

An onsite audit visit will generally include:

- a review of information and instructions given to applicants
- discussion with the Panel Members (including case specific discussions)
- introduction to delegated nurses or administrative staff involved in IME work
- a full and thorough inspection of the clinic, X-ray facilities, chest clinic and laboratory (if onsite)
- observation of processes including the physical examination of applicants
- an inspection of associated offsite laboratories and chest clinics
- review of TB management arrangements, including sputum collection arrangements and discussions with specialist chest physicians and treatment providers.

It is expected that Panel Members will be present during an onsite audit and the Department is notified of absence of key personnel prior to the visit. We appreciate Panel Members’ flexibility when scheduling onsite audit visits in consideration of departmental auditors’ availability. Onsite visits may be performed by the Department’s staff
located at overseas offices, intergovernmental partners, or other organisations if notified in advance, in conjunction with or on behalf of the Department.

Recommendations following onsite audits will be provided by the Department and Panel Members must abide by these.

It is the responsibility of Panel Members to ensure effective quality assurance practices are implemented across all aspects of IME processes and practices are continually monitored and reviewed to identify potential areas for improvement.

**Intergovernmental collaboration**

The Australian Government has close ties with its Migration 5 intergovernmental partners, namely United Kingdom, New Zealand, Canada and the United States of America., as part of the Migration 5 Health Working Group (M5HWG) in the area of migration health.

Panel Members should be aware that information collected by the Department about the Panel network is routinely shared with these Migration 5 partners. Applicant information is not shared. Applicants should be advised to contact the Department in relation to using their IME completed for other Migration 5 partners for the purposes of Australian IME.

Panel Members should be mindful that IMEs for intergovernmental partner countries differ. If clients have recently completed an IME for another intergovernmental partner country and request that exam components are reused for their Australian IME, Panel Members who are empanelled to partner countries should exercise judgment in considering the request. Individual exam components (such as chest X-ray) may be reused if the Panel Member is satisfied that it meets Australian requirements. It is the Panel Member’s responsibility to ensure the Australian IME is completed thoroughly and in line with Australian requirements.

eMedical does not have the functionality to transfer IME data between intergovernmental partner countries. Hence, all IME data will require manual data entry into the relevant intergovernmental partner country’s IME and graded accordingly.

**The Code of Conduct for Panel Physicians**

The M5HWG share a collective desire to support Panel Members, enabling them to work to high standards through the provision of processes that will help maintain and raise standards as well as provide quality assurance of, and training and education to, Panel Members. This collective desire aims to ensure consistent and reliable, high-quality IME related services are performed. This extends to the behaviour of Panel Members and the level of service provided to the individuals who undergo an IME. To that end, the M5WHG members have developed the Code of Conduct for Panel Members (the Code) to articulate the required standards of behaviour and conduct of Panel Members and define protocols and procedures if there is a breach of the Code.

It is essential that all Panel members are aware of, and comply with the Code. Panel Members who breach the Code may be subject to action at the discretion of the relevant Migration 5 country.

The Code of Conduct for Panel Physicians is accessible through the eMedical Support tab, under Support Material.

### 6. Applicant 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 program delivery, services or performance.

**How applicants can provide feedback to the Department**

Feedback may be provided by:
- **Phone:** 133 177 (in Australia only) between the hours of 9.00 am to 5.00 pm (AEST) – Monday to Friday with the exception of public holidays, to speak to the **Global Feedback Unit**

- **Post:** Department of Home Affairs, The Manager, Global Feedback Unit, GPO Box 241, Melbourne Victoria 3001, Australia

- Contacting an office of the Department:

Panel clinics and members are also encouraged to have their individual applicant feedback process through a survey, suggestion box or other mechanism they may enlist to get such feedback.

**Managing complaints**

The following is a suggested approach to resolving any issues that may arise in relation to the medical examination.

- Firstly, seek information on the applicant’s concerns by asking questions politely, and listen to what they have to say
- if the applicant is upset about any 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
- address the concerns and 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 the applicant is still concerned, refer them to the enquiry form found on the Department's website at:


Keep a detailed record of the event and advise the Department of any incidents, particularly if any threats were made against the clinic or clinic staff.

It is noted that the most common complaints relate to high fees, rude and impolite staff behaviour, lack of or poor facilities/service, long waiting times (for appointments as well as after arrival) and unnecessary tests.

**What the Department will do if a complaint is received**

The Department will investigate all complaints and provide the Panel Member with an opportunity to comment. The Panel Member must respond within 4 days, however an extension of time may be requested, if required. The Department 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.

If the complaint is determined to be significant, the Department will seek the Panel Member’s cooperation in addressing the issue.

### 7. Client Service

**Waiting periods**

Applicants should be able to make an appointment with panel clinics outside of Australia within a reasonable timeframe, preferably within two to three days. The wait time for an 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 the Department if timeframes are delayed for more than 10 working days or if they are experiencing issues managing appointments.

**Incidents involving applicants**

Clear and detailed procedures should be in place to deal with incidents that involve applicants or their representatives. These incidents may range from unruly behaviour to threats or violence. The procedures should take into account prevailing local laws and provisions. All such incidents should be reported to the Department.

**Clinic facilities and hygiene**

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

- obvious street sign/s to identify the clinic’s entrance
- a reception or waiting area large enough to accommodate the usual number of applicants and other people waiting with sufficient seating available
- toilets with hand cleaning facilities available within the clinic premises or in very close proximity, noting that applicants need to be supervised when providing urine samples
- heating and/or air-conditioning, where appropriate
- access for applicants with restricted mobility.

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

**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 table or bed
- medical equipment appropriate for an IME
- 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 applicant’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 under the age of 55 (see Radiology section)
- facilities to protect the applicants’ privacy when applicants undress including use of an adequate curtain or screen, and gown
• change rooms
• a facility for safe-keeping of applicants’ possessions such as locker.

Duration of medical examinations

The IME must be comprehensive, thorough and complete. The Department anticipates the history-taking and examination 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.

The entire IME, including the chest X-ray, urine collection and testing, blood collection and panel physician history and examination should be conducted without significant delay and can be expected to be completed within two hours, preferably during one visit.

Cultural, gender and language aspects of examinations

Panel Members should be aware of cultural and gender based expectations in relation to IME and history-taking. If the applicant does not speak the language of the Panel Member, arrangements are to be made for an interpreter.

Note: The Panel Member must be satisfied with 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.

Cases should be allocated to Panel Members in due consideration of the applicants’ cultural and gender related expectations. It is for this reason Panel sites are encouraged to ensure gender balanced staff at the site. Panel clinics may use locum Panel Members of specific gender if required.

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

Appendix E provides a diagram that you may wish to include when giving applicants information about the IME and we strongly recommend this diagram be on display in your clinic waiting room, change and/or examination room.

Chaperones

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

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 IME on children from orphanages with which they are associated. In the absence of alternative Panel Member options, any such associations should be declared to the Department for approval, prior to the IME.

IME of children for adoption visa applications have additional requirements and Panel Members should take care to ensure that these requirements are met. Section 35, Human Immunodeficiency Virus (HIV) and section 36, Hepatitis B and C, in Part B of the Instructions provide further details of these requirements.

Children requiring specialist assessments should not be referred to specialists associated with the orphanage.
Setting Fees for Australian IME

Panel Members outside Australia are not contracted to or paid by the Australian Government for providing IMEs. Panel clinics will charge applicants directly for examinations conducted by Panel Members and it is the responsibility of the applicant to pay the fee for an IME. Different payment arrangements exist for Refugee and Protection visa applicants and Panel Members should seek clarification with the Department if required.

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 the Department.

Fee schedules must be transparent and should be itemised by standard examination type – 501, 502, 707, 708, 716 and 719. An example template is offered below. The fee schedules should be displayed openly at the reception/waiting area of the clinic or on the clinic’s website (if available), and should clearly stipulate inclusions i.e. taxes, charges, TB costs.

<table>
<thead>
<tr>
<th>Item</th>
<th>eMedical Requirement Code(s)</th>
<th>0-2 years</th>
<th>3-10 years</th>
<th>11-14 years</th>
<th>15+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Examination</td>
<td>501</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>502</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>707</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Additional Tests</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>708</td>
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<td></td>
<td></td>
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<tr>
<td>Hepatitis C</td>
<td>716</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>TB screening test</td>
<td>719</td>
<td></td>
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</tr>
</tbody>
</table>

Fees should be all inclusive without any extra charges such as ‘administration or translation fees’. Panel Members should be aware of the Department’s position on costs related to TB management (both investigation and treatment). Further information is provided below.

Additional standard examinations such as 901 Mini-Mental State Examination (MMSE) and 903 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.

There should be no extra charge for repeat Blood Pressure check or Urinalysis tests, even if these are not conducted on the same day.

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 clinic’s reception area and on the Panel clinic’s website (if available) and be advised to applicants when arranging their appointments.

eMedical has functionality to allow Panel sites to record their fees for the Department’s record. It is recommended that this functionality is used.

Applicants should also be advised in advance of accepted methods of payment, such as use of credit card facilities, which is preferred.

Fully itemised receipts must be issued to every applicant and copies kept at the Panel clinic.

Fees, including courier charges for paper cases, should be collected before the examination.

Examination 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 individuals for the cost of further TB investigation is not supported by the Department as these significant costs may be a disincentive to applicants who require TB investigations, thus leading to poorer health outcomes. This may lead to detrimental impacts on future visa considerations, and more importantly, impact on public health within the community. The World Health Organization (WHO) position on TB management...
and treatment is that it is affordable. The *End TB Strategy* aims to bring the number of persons suffering catastrophic costs for TB investigation/treatment down to zero.

The Department requires that every panel clinic institutes a system whereby applicants who require further investigation to exclude active TB, and treatment (if required), will not be financially impacted. The clinic is responsible for these costs which may be incorporated into the fee for the 501 medical examination, which includes:

**603 Respiratory Specialist Investigation on Current Status of Tuberculosis**

- sputum collection, smear, culture, first and second line drug susceptibility testing
- molecular testing (if indicated)
- repeat chest X-ray (minimum three months after initial CXR)
- chest physician report.

Panel Members in some countries, especially those in lower TB burden countries, may refer applicants to the National TB Program, where costs may be borne by that program but should ensure that the Department’s requirements are still met. This includes:

**TB Treatment**

- clinical or case review by the TB nurse, panel physician or chest specialist
- medication
- Directly Observed Therapy (DOT) including medicine supply and supervision
- sputum testing during treatment as outlined in Part D of these Instructions
- routine laboratory testing as outlined in Part D or as recommended by the treating clinicians
- end-of-treatment chest x-ray.

Clinic accounts for managing the costs around this process should be transparent and will be subject to review by the Department.

There is no need to apply this requirement to the Australian Refugee and Humanitarian caseload as the costs for these applicants are paid by the Department.

Any other costs can be charged to the applicants. These might include hospital fees or fees associated with unforeseen complications. Please contact the Department if you would like further advice on this.

8. **Maintaining the Integrity of the Medical Examination**

Panel Members are accountable for the integrity of all facets of the IME and should make all possible attempts to ensure that aspects of the IME conducted outside the Panel clinic, such as specimen collection at an offsite pathology centre or at a specialist consultation, meet quality and integrity standards. This is a key consideration when considering the selection of these services and Panel Members should work with these services to ensure they maintain suitable integrity and quality assurance processes to conduct aspects of the IME.

If a Panel Physician delegates minor parts of the IME (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 including uploading the correct applicant’s chest X-ray image to eMedical. 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.

Any incidents involving attempted and/or actual breach of process or practice integrity must immediately be reported to the Department with details and available supporting evidence.
Informed Consent

All applicants agree to complete health aspects of the visa application process, either as part of their visa application, in eMedical, or on the paper forms.

A parent or guardian (necessary evidence may be required to verify this relationship) should sign on behalf of a client who is aged under 18 years (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 and guardians. Panel Members should make themselves aware of local regulations in this regard.

A signed consent (template available in eMedical) by the applicant must be obtained and a scanned copy attached to eMedical. The consent is already included in the Forms 26/160.

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 applicant at the time of their appointment and upload the image to their case in eMedical. Applicants are not required to bring passport size photographs with them to their appointment and this must not be requested by eMedical Panel clinics.

A scanned image of a photograph must not be uploaded because a scan is not a true image of the attending applicant’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 the eMedical Capturing Facial Images tip sheet. Use of a tripod, appropriate lighting and with the applicant sitting will improve photo quality. Photos should never be “cropped” but adequate zoom at time of picture capture should be used.

Note: Photos uploaded to eMedical should be clear and attached to the correct applicant’s record. Submitting health cases in eMedical with poor quality photos or photos of incorrect applicants could result in adverse audit findings against your clinic and will be recorded as an integrity concern. Continuing to submit incorrect photos is a performance issue and may lead to suspension or cessation of IME operations.

Confirming identity

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

Note: Panel Members must also ensure that the appropriate identity-control mechanisms are in place at all specialists, pathological laboratories and TB testing laboratories and treatment providers to which the applicant is referred. Identity checking must take place at all process points. eMedical referral letters should be used where possible to ensure that identity was verified by the above mentioned service providers.

Acceptable forms of identity documents

- current valid passport
- passport which has expired within two years of the health examination date
- current valid emergency travel document
- current valid temporary travel document
- United Nations High Commissioner for Refugees (UNHCR) Identification document
- ImmiCard

An 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 the applicants in the eMedical system. Please note that for UNHCR referred refugees the UN identity document will be accepted.
Alternative identity documents that can be selected in eMedical

<table>
<thead>
<tr>
<th>Identity Document</th>
<th>When 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>
</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 colour 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 the Department in writing.

<table>
<thead>
<tr>
<th>Country</th>
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<tr>
<td>Albania</td>
<td>Croatia</td>
<td>Italy</td>
<td>Oman</td>
<td>Slovakia</td>
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<td>Argentina</td>
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<td>Kuwait</td>
<td>Poland</td>
<td>South Korea</td>
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<td>Bahrain</td>
<td>Estonia</td>
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<td>Spain</td>
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<td>Belgium</td>
<td>France</td>
<td>Lithuania</td>
<td>Qatar</td>
<td>Sweden</td>
</tr>
<tr>
<td>Bosnia</td>
<td>FYROM</td>
<td>Macau</td>
<td>Russia</td>
<td>Switzerland</td>
</tr>
<tr>
<td>Brazil</td>
<td>Germany</td>
<td>Malaysia</td>
<td>Romania</td>
<td>Taiwan</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Hong Kong</td>
<td>Malta</td>
<td>Singapore</td>
<td>Thailand</td>
</tr>
<tr>
<td>Canada</td>
<td>Hungary</td>
<td>Montenegro</td>
<td>Saudi Arabia</td>
<td>Turkey</td>
</tr>
<tr>
<td>China (where verified by ID5)</td>
<td>Indonesia</td>
<td>Netherlands</td>
<td>Serbia</td>
<td>United Arab Emirates (UAE)</td>
</tr>
</tbody>
</table>

Under current contractual arrangements, the migration medical services provider in Australia 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 visa processing officer sending an approved form with the applicant’s photograph directly to the migration medical services provider. Details of these arrangements are available in the Procedural Instruction: Sch4/4005-4007: The health requirement.

If you are unsure about an identity document presented, please contact the Department. If the client cannot provide their passport or any approved alternative documentation, they should be advised to contact the Department as their immigration health examination cannot proceed, unless they meet exceptional circumstances listed below.

**Exceptions**

There are two scenarios where the IME can proceed if the individual does not have an original passport or any of the approved alternative identity documentation outlined above.
Scenario 1 – the examinee is a non-migrating family member

Please note non-migrating family members are no longer routinely required to undergo IME, but on occasion, the Department may request that they do. As these examinees (often children) may not have a passport or other accepted alternative documentation, Panel Members 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 examinee.

Scenario 2 – the Department’s approval is obtained

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

In either of these two scenarios, you can select ‘Other’ in eMedical, raise an identity concern and proceed with their IME.

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 the Instructions.

Please contact the Department if you need further advice about proceeding with a particular examination or have feedback about identity issues. Applicants can be referred to the Department’s website for more information about identity requirements.


Recording an identity concern

If there are concerns about the person attending the IME or identity documents presented, the IME should not be finalised as incomplete.

The table below provides advice on when you should raise an identity concern in the following situations, and attach a scanned colour copy of all identity documents presented to eMedical or paper forms 26/160:

<table>
<thead>
<tr>
<th>Identity concern MUST be raised if there are differences between the passport and eMedical</th>
<th>Identity concern does not need to be raised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/surname do not match (that is, the names are significantly different)</td>
<td>Minor name/spelling differences (for example: hyphen present/absent; middle name not entered; variations in how name is entered such as name and surname all on one line)</td>
</tr>
<tr>
<td>Gender is different in passport/realilty</td>
<td>Gender is not recorded in eMedical (listed as unknown)</td>
</tr>
<tr>
<td>Date of birth, including where the appearance does not appear consistent with the date of birth</td>
<td>If the appearance has changed purely due to age or because of medical procedures or accidents.</td>
</tr>
<tr>
<td>Country of birth (for example, passport indicates Lebanon and eMedical indicates USA)</td>
<td>The country of birth is not listed in eMedical</td>
</tr>
<tr>
<td>Country of birth (for example, passport indicates Lebanon and eMedical indicates USA)</td>
<td>There are minor discrepancies between the passport country of birth and eMedical. This includes when countries are re-zoned or declared independent (for example, Passport is Yugoslavia and eMedical is Serbia).</td>
</tr>
</tbody>
</table>
Identity concern MUST be raised if there are differences between the passport and eMedical

<table>
<thead>
<tr>
<th>Passport number</th>
<th>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, such as AC 123456 vs AC123456).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any difference in appearance of applicant with photo on the Passport, ID card or HAP</td>
<td>A passport with a different number (from the one in eMedical) is presented and the face of the applicant matches the photo in the passport. A copy of the new passport’s bio-details page should be uploaded to eMedical or attached to paper form 26.</td>
</tr>
<tr>
<td></td>
<td>The passport number and/or issuing country are not appearing in eMedical.</td>
</tr>
<tr>
<td></td>
<td>If the appearance has changed purely due to age or because of medical procedures or accidents.</td>
</tr>
</tbody>
</table>

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

**Imposters and Identity Fraud**

Panel Members must be reasonably satisfied that the client’s face, or images of the client’s face, match any officially recorded images of that client.

The Department must be notified immediately if:

- You reasonably suspect that the person presenting for the IME is not the client; for example, the person who is presenting for the IME does not appear to be the person in the photo(s) of the identity documents provided; or,
- The person who is presenting for a different stage of the IME does not match the client photo in eMedical; for example, the person who is presenting for the chest X-ray does not appear to be the same person in the photo recorded in eMedical.

Panel Members are advised not to finalise the IME or submit the case in eMedical if you suspect at any time that the person who presented for the IME is not the client and may be an imposter or any fraud has been involved in the process.

The client who has presented can be advised that their immigration health examination cannot proceed and they must contact the Department. However, if the client strongly insists on proceeding with the IME, Panel Members are advised to continue with the IME, however must not finalise or submit the case in eMedical.

Any evidence (for example, presenting person’s digital photo, a copy of the bio page of the passport or CCTV footage) that supports your suspicion of an imposter should be attached in an email and sent to: health@homeaffairs.gov.au.

The Department will then provide further advice on how to proceed with the case.
Specimen Integrity
Panel Physicians should perform blood and urine collection onsite. Sputum collection must occur onsite or at an approved TB laboratory. If the Panel Physician delegates these procedures to a nurse, phlebotomist or TB technician, the Panel Physician remains accountable for the integrity of this part of the examination.

Correct specimen collection will entail:

- confirming the identity of the applicant
- explaining the collection procedure to applicant
- 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 within the clinic or in very close proximity
- urine dipstick testing onsite
- accurate specimen identification using non-removable labels
- labels should be on the specimen container, not the lid
- incorporating appropriate security and/or coding procedures into the testing process for specimens and laboratory requests
- ensuring all pathology test kits are in date
- 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 applicants for transport
- participation in external quality assurance program.

Further detail about sputum collection is found in Part D of the Instructions.

9. Further Tests and Specialist Referrals

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

- strong suspicion of active TB
- 707 (HIV) examination is positive and not already known to the applicant.

Part B of the Instructions does, however, identify limited further circumstances where specialist reports should be obtained by Panel Members because the Department will likely require extra information. In some cases, eMedical will auto generate a request for additional information based on the findings entered.

In general, medical conditions that are not significant public health risks and/or do not need acute medical care will not need initiation of specialist referral by the Panel Physician as part of the IME. In such cases, the IME 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.

When making external referrals, Panel Members must explain to the applicants why further investigation is needed. Panel Members should also explain that the results will be sent directly from the specialist to the Panel
Member who must submit the reports to the Department, although applicants should also be offered a copy. Specialist referral letters should be generated via eMedical. The specialists should complete the relevant identity verification part of the referral letter and return it to Panel Member with their report. Panel Members should keep this as evidence of identity checking but it does not need to be uploaded into eMedical.

The choice of a specialist is not limited, however, high-quality reports in English are needed and substandard reports will not be accepted. Panel Members should only refer applicants to specialists in whom they have confidence in their clinical skills and reporting. If the case relates to TB investigation, Panel Members will have been advised which TB facilities should be used in some locations.

In general, Panel Members should ensure that the specialists:

- confirm the identity of the applicant against their passport and record their identity verification in their report (or provide confirmation of this on a copy of the eMedical referral letter returned to the Panel Member)

- provide detailed reports preferably in English, including results of all necessary investigations and a description of the recommended management and likely prognosis of the medical condition. Reports in language other than English must be translated before submission to the Department and the name of the person providing the translation should be provided.

If the requested specialist is not available in country, then the Panel Physician, or any other suitable specialist should review the applicant and provide a report to the best of their ability. For example, if there are no geriatricians or cardiologists available, a report from a specialist physician may be appropriate. A comment should be made on the applicant's case noting there is no specialist located in country.

If the applicant submits a report from their own treating doctor, this can be submitted as a supplementary document with a comment stating it is from the applicant's treating doctor.

All applicants should be explained in depth the timeframe for TB screening, results and treatment. Panel Members should explain to applicants that if they need TB treatment, evidence must be provided that this treatment has been conducted according to the requirements outlined in the Instructions at an approved DOT centre if one is listed at Appendix D of the Instructions.

If the applicant chooses to be treated by a physician of their choice, and supporting documentation does not provide evidence that treatment was completed according to the Instructions, their health assessment for the purpose of an Australian visa will be delayed by at least 12 months following the completion of treatment. By this time, a new IME will be required as the previous ones would have expired, and the costs for a new IME will be borne by the applicant.

It is important that the reasoning for the above is fully explained to the applicants as this is a common source of applicant complaints.

10. Submitting Immigration Medical Examination results

Submiting in eMedical

All eMedical enabled clinics must use eMedical to submit all IMEs conducted at their site. eMedical is designed for use in ‘real time’ and it is recommended that the examination findings are recorded in eMedical as the examination progresses. This ensures timely generation of additional examinations required based on the results entered for the current examinations.

IMEs completed in eMedical will be submitted automatically to the Department once all required health examinations are finalised. There is no manual document handling required.

IME 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.

Panel clinics have a responsibility to manage their pending caseload to ensure prompt submission of cases and to avoid any delays and inconvenience to applicants. Panel Members should regularly review their eMedical inbox.
any applicants decline to return or complete the requested examinations, the case should be finalised as incomplete. See below for further information on finalising cases as incomplete.

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**

For Panel Members 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**


Panel Members using paper forms for the IME must check their completeness and correctness before submission, including confirmation of the applicant's identity and the client declaration.

Panel Members should check that:

- the current version of the Form (26 or 160) is used
- examination results and comments are completed in English and are legible
- forms are signed by the applicant and the Panel Member (forms completed and signed by non-Panel Members will not be accepted)
- any additional test/ specialist reports and the CXR film (clearly identifying the applicant) are attached to the Forms 26/160 as applicable.

**Where to send completed paper forms**

Panel clinics outside Australia that are not eMedical enabled must send the completed forms directly to the Department's 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.


Panel radiologists should send the completed chest X-ray examination paper Form 160 and related films directly to the examining Panel Physician so that they, in turn, can complete the IME, 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 should the original records be given directly to the applicants, their representatives or other parties. The Department will not accept documentation sent by applicants, their representatives or other parties.

Upon request, Panel Members can provide applicants with copies of any forms, diagnostic reports or test results without permission from the Department. Panel Members may 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 medical examinations.

Copies of medical records and reports should not be provided to family members, migration agents, or anyone else, without the written permission of the applicants.
If an applicant has any queries in relation to the health requirements, Panel Members should refer the applicant to his/her visa processing officer/centre.

Incomplete Immigration Medical Examinations

IMEs that have already commenced should not be kept pending indefinitely while waiting for the applicants to provide new information or to complete tests, even if the case is awaiting identity verification only.

If the applicant:

- indicates that he/she is withdrawing from the application process
- does not proceed with the IME
- has not returned to complete any other additional required examination within four weeks
- has not supplied the 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 all 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 IME process, including all attempted contact with the applicant 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 IME’
- send all the partially completed documents to the Department.

Declaration by the examining Panel Member

In making a declaration in relation to paper cases:

- the Panel Member’s name must be printed or stamped clearly on Forms 26/160 – the name must be consistent with that provided to the Department in the panel membership application/primary identity document and the use of all other versions of a Panel member’s name (such as aliases) is unacceptable
- the Panel Member must sign the declaration once the results of the physical examination are recorded fully and the Panel Member has completed his/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 Member is acknowledging responsibility for the integrity and quality of the entire IME process.

11. Other Panel Physician Roles

Immunisation

With the exception of some specific applicant groups, such as refugees, it is not mandatory for Panel Physicians to provide immunisations. Immunisations are not currently required as part of the IME, unless special arrangements apply.
Parents should, however, be 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. Panel Physicians should advise parents to take their children’s immunisation records to Australia as these will be required for school enrolment and other settlement related purposes, including provision of family benefits.

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

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


See: https://www.humanservices.gov.au/individuals/enablers/immunisation-requirements

Communicable disease

In response to potential threats of importation of communicable disease, in the interests of public health, the Department, at times, may request the assistance and cooperation of the Panel network 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.

Information about communicable diseases and threats to public health can be found 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 specific requirements by the visa processing office when it is required. This is not part of the IME but a separate requirement for visa processing.

The following guidelines have been produced to assist Panel Physicians when counselling applicants 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 applicant by the Panel Member collecting the sample.

The Panel Member should explain:

- undergoing DNA testing is voluntary for the applicant
- how samples will be collected
- that the test is used to determine biological relationships
- the results of the test will be accurate and reliable in determining biological links between the applicants and are considered conclusive in parentage-testing case
- counselling options for applicants 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 applicant may want to receive counselling. The Panel Member should refer the applicant 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 (DHC) to Refugee and Special Humanitarian Program (RSHP) visa holders who are outside Australia. Usually, this is conducted within three days of the applicant’s intended departure for Australia.

Panel Members may be asked to conduct DHC for applicants referred by the Department. In the event 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 Instruction: Sch4/4005-4007* for information on requirements for Protection Visa applicants.
Part B: The Medical Examination

This part of the Instructions provides advice for Panel Physicians on how to complete the medical aspects of the IME.

IMEs are completed using eMedical (examination 501), or the paper form 26 only where eMedical is not enabled.

Applicants may not be aware of the significance or relevance of parts of their medical history. In some cases, there may be concealment due to concern that their visa may be delayed or denied.

It is the Panel Physician’s responsibility to ensure that all relevant findings are identified and recorded accurately.

12. Medical History

Applicants may attempt to conceal significant findings. Panel Physicians must review applicant health declarations in the Medical History section and take note of any abnormalities. The Panel Physician should note that third parties may have completed the health declaration and/or the medical history, and they must ensure that the applicant understands the questions and reconfirm the answers. Remember that the applicant’s declaration is a legal document.

A comprehensive medical history must be taken. The medical history questions in the 501 examination (or on the paper form 26) are designed to assist the Panel Physician to assess aspects of the applicant’s health of particular relevance and importance to the Australian Government’s health requirements. However, Panel Physicians should also be asking other questions in order to obtain comprehensive histories and/or verify the applicant’s declarations. If there is no medical history declared, the Panel Physician must verify this with the applicant.

Panel Physicians should specifically review comments regarding previous hospitalisations, institutionalisation for any 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 that may not be obvious, particularly in children.

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

13. Physical Examination

Applicants are required to be undressed to underwear for examination (females should keep brassiere on). Applicants may not disclose all relevant medical history, and therefore it is important to conduct a full and appropriate physical examination.

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.

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 applicants.

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.

14. Height, Weight and Head Circumference

The applicant’s height and weight should be determined accurately and recorded in centimetres and kilograms respectively. eMedical automatically generates BMI.

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

Children who are significantly underweight for their age (under 3rd centile) will generally 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 (see Appendix G).

Growth charts from the Panel Members’ own country are likely to be of the most use. The following are supplied courtesy of the respective agencies and can be accessed through the following links:

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

WHO: https://www.who.int/childgrowth/standards/en/

15. Eyes

Clinical examination of the eyes and measurement of visual acuity can be done together but must be tested separately if poor vision is identified. 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 applicants and children, E charts or picture charts should be used.

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

Fundoscopy is required routinely to assist in identifying suspicion of end organ damage 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.
16. Urinalysis

Every applicant who is aged five years or over must have their urine tested for the presence of albumin, sugar and blood. Children aged four years and under should be tested if clinically indicated, for example when there is a history of kidney disease.

Urine must be passed at the time of the IME in a secure collection area in the panel clinic. To maintain the integrity of the test, the applicant must be escorted and supervised during access to the toilet. There should be no water available inside the toilet cubicle and blue dye should be used in the toilet bowl if available, to prevent dilution of the specimen with water from the toilet bowl. Personal items such as handbags should not be allowed inside the toilet. Provide gowns or ensure the applicant’s pockets are empty and restrict any personal items in the toilet cubicle.

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.

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

Abnormalities (trace or more of protein, blood or glucose) entered into eMedical will automatically generate a repeat urinalysis. This should be done immediately, before the applicant leaves the premises, and with no additional charge. 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 ‘1+’ 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 can be found at the following link:


If creatinine > 2.0 mg/dL (177 µmol/L) and/or the eGFR is less than 60 ml/min, refer the applicant to a nephrologist for investigation.

If there is concomitant diabetes, an endocrinologist may be a suitable alternative.

Haematuria

If the repeat urinalysis shows 1+ or more of blood, then eMedical will automatically 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 prior counselling as mentioned above, female applicants are menstruating at the time of the examination, a 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. These cases should be ‘B’ graded.

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 applicants.

If the applicant 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 applicant is known to be diabetic.

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

### 17. Cardiovascular Disease

Examination of the cardiovascular system should include but not limited to pulse rate and rhythm, auscultation of heart sounds/detection of any murmurs and blood pressure. The aim is to identify potential significant cardiovascular conditions that may require medical intervention.

**Hypertension**

If the initial BP is high (systolic >160 mmHg and/or diastolic >100 mmHg), it should be repeated immediately. Further repeat blood pressures can be done at the Panel Physician’s discretion. If these remain elevated and hypertension is detected, further investigation is needed (via referral to cardiologist) only where:

- end-organ complications, such as ischaemic heart disease, renal impairment, cerebrovascular or peripheral vascular disease, or retinopathy are present or suspected.
- the repeat BP is >160 mmHg systolic and/or >100 mmHg diastolic.

If the applicant’s repeat BP exceeds 160/100, then serum creatinine (examination 704) is required, even in the absence of proteinuria. eMedical will automatically generate a request for serum creatinine where required.

Specialist cardiologist review is unlikely to be indicated for those who are known to be hypertensive without complications. Reports from the applicant’s own treating doctor can be provided as supplementary documents if available. Routine electrocardiograms (ECG or EKG) are not required for the purposes of the health assessment and should not be uploaded into eMedical.

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 may require no further action. Cases of cardiac conditions which are unstable, progressive or complicated should be ‘B’ graded.

Unstable or progressive symptomatic or complicated cardiac conditions require referral to cardiologist for further advice. The specialist’s assessment should address any history, diagnosis, clinical examination findings, treatment needs and expected prognosis.

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

A thorough respiratory examination must be performed, including but not limited to assessment of respiratory distress and chest auscultation of the bare chest in all cases. Female applicants should not be asked to remove their brasserie for this.

Respiratory conditions

The IME 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.

Applicants with examination findings or X-ray changes indicative of other respiratory disorders, for example malignancies, emphysema and bronchiectasis, may be referred for a specialist assessment where clinically indicated. Unless there are clear clinical indications, or for diagnostic purposes, additional investigations, which may include CT scan, lung function testing or biopsy, are not necessary. Submit the 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.

19. 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 applicants.

A basic cranial nerve examination, and peripheral nervous examination including, gait and balance should be performed. All neurological abnormalities should be recorded. Medication and other treatments must be noted.

It is particularly important to assess the effect of neurological and musculoskeletal disorders on an applicant’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 his/her 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.

An Activities of Daily Living (examination 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.

20. 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 for non eMedical cases.

The MMSE is one of many screening tools that can be used to assess cognitive decline. The tool should be adapted, as appropriate, linguistically and culturally. The test questions should be performed in the applicant’s own language or with the assistance of an interpreter. If a language barrier to assessment is present, this should be recorded. eMedical will generally automatically ‘B’ grade the case. These cases should be B graded if manual grading does not occur. The MMSE tool is available in eMedical (examination 901) and can be added as necessary.

If Panel Physicians suspect cognitive decline, a psychiatrist’s or geriatrician’s opinion is required.

Intellectual ability

Referral for psychological or psychiatric assessment 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, 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.

21. 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 aged five years and under.

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:
Delayed Milestone | Normal Milestone
---|---
Cannot hold head up unsupported at eight or more months of age | (normal - two months)
Cannot sit unsupported at nine months | Eight months
Cannot walk at 18 months | 13 months
No words by 18 months | 15 months
No two to three-word phrases by 24 months and 36 months respectively | 21 months and 36 months respectively
Moro reflex persisting at six or more months of age |

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 (Paediatric Report – examination 124). 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.

### 22. Gastrointestinal System

Examination of the gastrointestinal system should include, but is not limited to, examination of abdomen and detection of abnormalities (jaundice, hepatomegaly, tattoos and evidence intravenous drug use). Investigation may 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.

### 23. Musculoskeletal System (including mobility)

Examination of the Musculoskeletal system should include but not limited to gait, power and general functionality. Where indicated, a detailed examination should be performed if abnormalities are detected or reported. 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 (examination 903 or Appendix H) is required if there are musculoskeletal conditions that interfere with activities of daily living. Details of prescription medication should be recorded.
24. 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.

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. Exceptions might include severe psoriasis requiring use of prescription medication.

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 relevant specialist for assessment and a report is required. Extra-pulmonary TB should be considered as part of the differential diagnosis and explored.

Examination of the external genitalia is not required.
Gynaecological examination (vaginal or pelvic examination) is never indicated. If there is a clinical suspicion of gynaecological malignancy, refer the applicant to a gynaecologist.

25. Evidence of Drug-Taking

Details should be recorded of any indications of possible drug abuse, such as puncture marks or altered cognition. 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 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 case should be ‘B’ graded.

26. Breast Examination

Breast examination is not routinely required as part of the IME. It is only required if there are clinical indications.

Clinical indications include a history of breast cancer or suspicious breast lumps, for example, not benign disease, a strong family history, or detection of axillary lymphadenopathy. 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 the applicant 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.

History of malignant disease requires specialist review or a report detailing the condition, current state, any treatment and prognosis. If less than 5 years since treatment, a recent (not more than 12 months) specialist report is required.

Benign breast lesions such as fibroadenoma, or fibrocystic disease do not need to be recorded in eMedical and can be ‘A’ graded.

27. Endocrine System

Applicants 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, the applicant should be encouraged to see their own doctor for medical opinion and/or treatment.

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. Applicants 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 referral to endocrinologist is required to exclude malignancy.

28. 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.

If the applicant 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 applicant need to be recorded. That is, it should be noted if the applicant uses lip-reading, signing, reading or writing.

If severe hearing impairment is detected, especially in children and younger adults, formal audiological assessment and/or a report from a specialist detailing the diagnosis and further management including any special needs is required.

29. 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 applicant’s capacity for independent living and/or employment, and provide full details. The ADL assessment (examination 903, or Appendix H) needs to be completed for any applicants 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 applicant'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 applicant, or which will be needed in the future.

30. Human Immunodeficiency Virus (HIV) Testing

Testing requirements for HIV will be generated based on the type of visa and intended occupation in Australia. A summary is provided in the following table.

<table>
<thead>
<tr>
<th>Type of Applicant</th>
<th>Test for HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent visa applicants aged 15 years or older</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**Type of Applicant** | **Test for HIV**
--- | ---
Non-migrating relatives of Permanent visa applicants, aged 15 years or older, if requested by the visa officer to undertake medicals | Yes
Children who have been, or are to be, adopted by Australian residents | Yes
Unaccompanied Minor Refugee Children | Yes
Children aged 14 years of age and younger with clinical suspicion for HIV infection, a history of blood transfusions or haemophilia, or if the mother is HIV-seropositive. | Yes
Temporary Entry Applicants with clinical signs of AIDS | Yes
All applicants who intend to work as, or study to be a physician, nurse, ambulance paramedic or dentist* | Yes
Persons known or found to be infected with Hepatitis C | Yes
Persons where there is evidence of previous or current intravenous drug use | Yes
Persons where active TB is diagnosed | Yes

* Other allied health professionals including physiotherapists, occupational and speech therapists, laboratory technicians and veterinarians, do not routinely need HIV, Hepatitis B or C testing.

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

The identity of applicants must be confirmed to prevent substitution. Specimens should ideally not be labelled with the applicant’s name due to privacy and security reasons and be labelled with bar-coded identifiers. The Panel Member should retain the register deciphering the coding to the applicant’s name. When the pathology result is received, the Panel Member should write the applicant’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 applicant by the Panel Physician.

The Panel Physician should, during the medical consultation, also explain:

- that the HIV-test is required as a part of the IME
- 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.

**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, such as one that detects the p24 antigen. 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 it is 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 an applicant 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 applicant to their own physician or a suitable specialist for follow-up counselling and management. The Panel Physician must record that the applicant 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 the Panel Physician is unsuccessful in contacting the applicant, this should be recorded on the applicant’s case and finalised as incomplete. All efforts to contact the applicant must be detailed and the Department should be notified that the applicant may not be aware of the diagnosis.

If an applicant is already on HIV treatment, request a report from their treating specialist and perform Hepatitis C test. If applicant is not being treated, obtain CD4 count, viral load and specialist physician review.

All applicants with known HIV should be reported as positive in the 707 exam, even if their viral load is undetectable due to treatment.

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 enquiries by applicants about the Australian health requirements should be referred to their visa processing officer.

### 31. Hepatitis B and C

Where indicated, applicants 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><strong>Unaccompanied minor refugee children</strong></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><strong>All visa applicants intending to work as or study to be a physician, nurse, ambulance paramedic or dentist</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Persons where there is evidence of previous or current intravenous drug use</strong></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 an applicant 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. Reports should include serological markers, Hepatitis B DNA or Hepatitis C RNA and comment regarding management options, including any recommendations for drug treatment.

All members of a Hepatitis B carrier’s family should be encouraged to get the Hepatitis B vaccination if not already undertaken.

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 ‘A’ graded.

32. 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 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 IME. Unless treatment has failed or follow up is needed in Australia, the case can be graded ‘A’.

33. Grading ‘A’ or ‘B’

The ‘A’/‘B’ grading system is designed to allow rapid identification of applicants who may have significant conditions or findings. eMedical assists by automatically grading ‘B’ in some cases, where the applicant’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 full 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 that the Panel Physician decides should reflect the 502 examination.

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

Conditions or findings that are significant

A significant condition or finding has current or foreseeable future implications for the applicant’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, grade ‘B’.

**Conditions or findings that are not significant**

A condition or finding is not significant if it does not have current or future implications for the applicant’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. Appendix F provides more guidelines for grading specific 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 eMedical 501 or 502 examination 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><strong>Insignificant Medical Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
</tr>
<tr>
<td>Allergic rhinitis</td>
</tr>
<tr>
<td>Asthma (controlled)</td>
</tr>
<tr>
<td>Astigmatism (corrected)</td>
</tr>
<tr>
<td>Breast fibroadenoma</td>
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<tr>
<td>Dental disease</td>
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<tr>
<td>Dermatitis</td>
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<tr>
<td>Dyspepsia</td>
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<tr>
<td>Eczema</td>
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<tr>
<td>Fibrocystic disease</td>
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<tr>
<td>Fibroids</td>
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<tr>
<td>Haemorrhoids</td>
</tr>
<tr>
<td>Heartburn</td>
</tr>
<tr>
<td>HRT (hormone-replacement therapy)</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
</tr>
<tr>
<td>Hypo/Hyper Thyroidism (uncomplicated)</td>
</tr>
<tr>
<td>Infertility</td>
</tr>
<tr>
<td>Keloids</td>
</tr>
<tr>
<td>Lipoma</td>
</tr>
<tr>
<td>Menopause</td>
</tr>
<tr>
<td>Minor Surgery: Appendectomy, Caesarean section, Cholecystectomy, cosmetic surgery, nasal operations or corrections, Rhinoplasty, Tonsillectomy</td>
</tr>
<tr>
<td>Myopia</td>
</tr>
<tr>
<td>Otitis externa</td>
</tr>
<tr>
<td>Prostatic hypertrophy</td>
</tr>
<tr>
<td>Refractive errors of vision (for example, myopia)</td>
</tr>
<tr>
<td>Tattoos</td>
</tr>
<tr>
<td>Uterine fibroids (fibromyoma uteri)</td>
</tr>
<tr>
<td>Varicose-vein surgery</td>
</tr>
<tr>
<td>Vitiligo</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Insignificant X-ray Findings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aortic calcification</td>
</tr>
<tr>
<td>Apical capping (with smooth border)</td>
</tr>
<tr>
<td>Atelectasis</td>
</tr>
<tr>
<td>Azygous fissure/lobe or other accessory fissions</td>
</tr>
<tr>
<td>Breast implants</td>
</tr>
<tr>
<td>Cardiomegaly, mild (CTR &lt; 60%)</td>
</tr>
<tr>
<td>Dextrocardia</td>
</tr>
<tr>
<td>Nipple shadows</td>
</tr>
<tr>
<td>Pectus excavatum</td>
</tr>
<tr>
<td>Raised hemi-diaphragm</td>
</tr>
<tr>
<td>Rib abnormalities (for example cervical ribs, previous rib fractures, bifid ribs, congenital rib fusion)</td>
</tr>
<tr>
<td>Scoliosis</td>
</tr>
<tr>
<td>Single solitary calcified nodule &lt; 1cm</td>
</tr>
<tr>
<td>Bony island</td>
</tr>
<tr>
<td>Single fibrotic streak/ band/ scar- rest of lung fields normal</td>
</tr>
<tr>
<td>Minimal costophrenic angle blunting</td>
</tr>
</tbody>
</table>
‘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 of the 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 6/24 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 applicant 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.
- Normal chest X-ray (where indicated).

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

‘B’ Grades

‘B’ grades should always be recorded when any of the conditions in the above section are not met, when medical conditions or findings are present, or if the Panel Physician has reservations about an applicant’s fitness. Panel Physicians should ensure to provide sufficient notes on reasons for B-grading the case.

‘B’ grade does not mean that an applicant will not meet the health requirement and does not mean that the applicant 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. Please note that although it is not possible to override the automatic B grade in eMedical, the Panel Physician should use clinical judgement and if they disagree, they should indicate this in the Comments section.

34. 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 examination (chest clinic) which is auto-generated if the radiologist records a strong suspicion of active TB (refer to question 7 on 502 examination in eMedical).

Other deferral requests are generated by a MOC. When this occurs, applicants 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 applicant must return to the panel clinic where the original IME was conducted.

For eMedical cases, the applicant 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 applicant has relocated.
Part C: Completing an Immigration X-ray Examination

This part of the Instructions provides advice for Panel Radiologists on how to complete an immigration chest radiography (CXR) examination.

CXR examinations are completed in eMedical (examination 502) by uploading the compressed X-ray image in DICOM format and completing the radiology report. For paper cases, the printed CXR image should be attached to the completed paper form 160.

All CXRs should be taken at the Panel radiology clinic. Previous (old) CXRs provided by the applicant can be attached in eMedical if digital, or attached to paper cases as supplementary materials.

35. Taking the Chest X-ray

X-ray images for eMedical

Both digital radiography (DR) and computed radiography (CR) are acceptable modalities

Images must be submitted as DICOM files. If additional images are attached then a description should be provided, for example, left lateral image. Larger file sizes of 4-5 Mb are acceptable (the relevant box should be checked in eMedical).

Film size for paper cases

For paper cases (35cm x 42cm), PA films should be provided. Images on CDs are not accepted in lieu of hardcopy prints as there is often software incompatibility.

Radiographic technique

- all adult CXRs should be taken in the posteroanterior (PA) projection to reduce cardiac magnification
- 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 applicant 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
- 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
- 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 (six feet)
- all CXRs should include costophrenic angles
- apices should be clearly seen (without overlying clavicles).
If the lungs are of different translucencies 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
- dirty screens
- foreign bodies in cassettes
- jewellery
- technical artefacts.

**Additional Views**

An apical lordotic view should be done for suspicious opacities over ribs, clavicles or other structures. Other views may be used at the discretion of the radiologist.

Ultrasound imaging or lateral decubitus radiographs can be useful to exclude pleural effusion if there is significant costophrenic angle blunting.

Sometimes a nodule in the lower zones can be difficult to differentiate from a nipple shadow. Repeat X-ray should be taken 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 record all abnormalities in the 502 examination comments field.

Computerised Tomography (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 applicants, male and female aged 55 years and under, and double wrap around shielding for pregnant women who choose to proceed with the chest X-ray
- 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 or using fluoroscopy
- 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 CT scans
- minimising radiographer exposure, including by use of lead shielding, if required
- ensuring all staff in the radiography working area wear dosimeters (radiation badges) and that these are checked regularly for radiation dose and action taken as needed
- the use of a red light indicator at the time of exposure
- displaying radiation hazard signs.
X-ray image identification

The X-ray image must indicate:

- the date of the examination (using the Gregorian calendar)
- HAP ID or Passport Number
- applicant’s full name in English
- applicant’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 CXR images.

Female applicants

Female applicants 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. Radiographers must ask female applicants of child-bearing age about pregnancy and the date of the last menstrual period.

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 (refer to HPA: Protection of Pregnant Patients during Diagnostic Medical Exposures to Ionising Radiation (RCE-9) March 2009).

It should be noted that 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 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. 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.

Panel radiologists and radiographers have an ethical obligation to ensure pregnant applicants are adequately protected. Be vigilant in avoiding unnecessary radiation exposure. Panel Members must adhere to national guidelines where applicable.

Applicants from lower TB risk countries are not required to complete a CXR if pregnant. Evidence of pregnancy should be provided, for example, a certificate from the applicant’s own doctor. If the clinic is eMedical enabled, in the 502 examination’s 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 the CXR and therefore the finalisation of both their IME and visa application, until after giving birth, or
- proceeding with the CXR, with appropriate abdominal lead shielding, after completion of the first trimester.

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

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

For the list of lower/ higher TB-risk countries, please see Countries with low risk of tuberculosis under the What health examinations you need section at the following link:


How to manage CXRs deferred until after childbirth

For eMedical cases, if the question “Has the client 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 CXR after childbirth. eMedical enabled clinics must provide these applicants with the ‘Pregnancy Deferral Letter’ that is generated via eMedical to confirm this and present it 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. The case should be graded ‘B’.

Children

CXRs are required for children aged 11 years and above and/ or if there are clinical indications in younger children, for example, if there are respiratory signs on examination, and/ or if the 719 examination (TB screening test) is positive.

In children, two views are required; a lateral view (510 examination) as well as either an anteroposterior or a posteroanterior view (502 examination).

Panel Physicians can add a 502 examination and/ or a 510 examination in eMedical. Reasons for adding this should be clearly outlined by the Panel Physician in the medical examination section.

Children who are non-migrating family members of permanent visa applicants are exempt from undergoing routine CXR if they are from a lower TB risk country or not suspected of having a significant medical condition.

Minimising radiation exposure as outlined above is essential.

36. Film Examinations and Reporting

The X-ray image is to be read by the Panel Radiologist using specialised equipment designed for that purpose, using a medical grade monitor with a minimum resolution of 3MP. It is important that Panel Physicians review both the X-ray image and the radiologist’s report prior to submitting the case to ensure accuracy of reporting and to address any abnormalities. Panel Physicians should ideally have access to specialised reporting equipment but this is not mandatory.

The radiologist should pay particular attention to the so-called ‘hidden’ areas:

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

Reporting TB findings

Radiologists should take particular concern when reporting findings which could be consistent with TB disease.
Findings which can be consistent with active TB

The following findings should be recorded in the 502 examination or on the paper form 160 and the lung fields (Question 5) reported abnormal. ‘B’ grading should be assigned to these cases if eMedical does not automatically assign a ‘B’ grade to the 502.

- any cavitating lesion or “fluffy” lesion
- 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 ≥ 1 cm thick at any point).

Minor findings, occasionally associated with TB disease

The following findings should be recorded in the 502 examination or on the paper form 160 and the lung fields (Question 5) reported abnormal. ‘B’ grading should be assigned to these cases if eMedical does not automatically assign a ‘B’ grade to the 502.

- 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

The following findings should be recorded in the 502 examination or on the paper form 160 but the lung fields (Question 5) can be reported as normal. An ‘A’ grade is appropriate in the absence of additional findings.

- single fibrous streak/band/scar
- pleural capping with a smooth inferior border (<1 cm 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.

Strong suspicion of active TB

If radiologists or Panel Physicians believe there is a strong suspicion of active TB, based on radiological and/or clinical findings, then immediate further investigation is warranted. A positive answer to Question 7 in eMedical automatically generates a requirement for further testing.

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.

If in doubt, the Panel Radiologist should record the findings in Question 6 (‘Evidence of Tuberculosis (TB)’), but tick “no” to Question 7 (‘Are there strong suspicions of active Tuberculosis (TB)?’). The MOC will then provide an opinion about whether further investigation is required.
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.

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

**Grading ‘A’ or ‘B’**

Panel Radiologists are required to grade the X-ray examination based on identification of a condition. Identification of significant condition requires the radiology exam to be ‘B’ graded. For general guidance on grading, refer to section 37 (Part B) above.

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

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

- single solitary calcified nodule < 1cm
- bony island
- single fibrotic streak/band/scar- rest of lung fields normal
- minimal costophrenic angle blunting
- aortic calcification
- apical capping (with smooth border)
- atelectasis
-azygous fissure/lobe or other accessory fissures
- breast implants
- cardiomegaly, mild (CTR < 60) and no other signs of cardiac insufficiency, chamber enlargement or hypertrophy, pulmonary hypertension and an 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 in the general supporting comment field 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
- pacemaker
37. 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. The Department routinely audits 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

38. Screening

The IME places particular emphasis on the diagnosis and management of Tuberculosis (TB). This section provides technical advice and specific instructions to Panel Physicians on this topic.

The diagnosis of TB in applicants 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. Applicants may not provide an accurate medical history or attempt to send a substitute or in extreme circumstances, seek investigation and treatment prior to attendance at the IME. The Instructions attempt to provide some guidance to Panel Physicians to minimise the impact of these types of behaviours.

Why 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 to individuals, including social consequences, are minimised.

Australian migration legislation requires that entrants to Australia are free from active TB. The IME aims to identify those applicants 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 the migrating populations.

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

- medical history
- physical examination
- chest radiography (CXR)
- testing for previous exposure to tuberculous antigens
- sputum testing for Mycobacterium TB (MTB)
- testing for HIV disease.

Medical history

A high index of suspicion is vital to the diagnosis of TB. Most visa applicants will be asymptomatic. The applicant’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 to or residence in a high incident TB country.

Noting that visa applicants may not have provided a comprehensive medical history in the first instance, the Panel Physician may need to interview applicants again if, for example, the CXR findings are suggestive of a history of TB.

**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.

As indicated above, visa applicants may infrequently admit to symptoms.

**Previous treatment**

Where applicants give 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 CXRs and any laboratory testing, drug regimen (including dosages) in generic form, comment about whether Directly Observed Treatment (DOT) was provided, 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 it is not in English, a clear translation should be provided by the Panel Physician.

Important details about previously treated TB should include clinical signs, diagnostic tests such as 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.

If records are unavailable, or if the records do not contain the level of detail outlined above, for example if the treatment was undertaken many years previously, the Panel Physician should make a clear note of this on any records uploaded and in the case file, and summarise as much as possible from the medical history provided by the applicant.

**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 medical history is provided particularly in countries where significant stigma still applies to a diagnosis of TB.

**Previous abnormal CXR**

If previous CXR images are available, these should be uploaded if they are in digital format. If they are 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 the IME and should not be recorded in the history.
Visa applicants with a history of close household contact with TB within the past five years will require additional testing. A 719 examination (either Tuberculin Skin Test or Interferon Gamma Release Assay) should be added in eMedical by the Panel Physician, regardless of the age of the applicant, and whether or not a CXR has already been performed. Very young children (aged two years and under) should be referred for specialist review and CXR regardless of the result of the 719 examination.

Other contacts who are not visa applicants should be referred to local TB authorities.

Additional information about contact tracing for active TB cases which are diagnosed during the IME, i.e. newly diagnosed or index cases, is found below under Section 46 Contact Tracing of the Instructions.

All applicants with a positive 719 examination require a CXR, if not already taken as part of the IME, to exclude active pulmonary TB. In children, a lateral CXR as well as a PA image is required.

If the 719 examination is positive, but the CXR normal, the case should be ‘B’ graded.

If the 719 examination is negative, the case can be ‘A’ graded if there are no other significant conditions.

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 latent TB disease. These include:

- younger age (<35 years of 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’).

Chest radiography

Details about CXR requirements, including reporting requirements, are outlined in Part C of the Instructions.

Tuberculin Skin Test and Interferon Gamma Release Assay Tests

Tests for latent M. tuberculosis infection (LTBI), Tuberculin Skin Test (TST) and Interferon Gamma Release Assay (IGRA) are required in one of two situations – history of close household contact of an index case, or for initial screening in children from higher TB burden countries.

1 Systematic screening for active TB, WHO 2013
Paediatric screening

Children from higher TB burden countries are a highly vulnerable group and testing for previous exposure to MTB is designed to both strengthen screening for active TB and, if active disease is excluded, 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, regardless of visa status.

Departmental Policy requires that the following applicants undergo a 719 examination (either a TST or IGRA):

- Children aged two to 10 years, who are from a higher risk TB country, and:
  - are applying for a permanent or provisional visa, or
  - are applying for a temporary visa and declare close household contact with TB within the last five years.

- Children aged two to 10 years, and:
  - are applying for refugee or humanitarian visas, or
  - are asylum seekers within Australia, and/or

- Children aged less than two years, regardless of whether or not they are from a higher or lower TB risk country, who:
  - declare close household contact with TB, or
  - display clinical symptoms of TB, or
  - are immunocompromised.

  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 examination.

Choice of TST or IGRA

Both TST and IGRA measure the immune response to Mycobacterium tuberculosis antigens.

For the purposes of the IME either can be used. Parents or guardians should be provided with options after they have been counselled about the cost, the need for a repeat test (if TST), and the availability of either test.

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. Generally, IGRA tests are preferred where available, particularly in children under five years who have received the BCG vaccine especially in the previous five years. TST is generally preferred in the absence of previous BCG vaccine or where IGRA is not available.

BCG status should be recorded in the General Supporting Comments in the 501 examination or on the paper form 26.

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 (positive molecular test or positive smears or cultures of a sputum or other specimen), then a TST/ IGRA is not required. The medical history should be noted under the comments tab in the 719 examination (e.g. past history of TB) and the applicant can proceed directly to CXR.
In these cases, the 719 examination can be finalised as incomplete noting the reason/s.

Note that previous BCG vaccination is not an exemption to TB screening test. BCG status should be recorded in the General Supporting Comments.

**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 in eMedical or on the paper form 26. It is not necessary to upload a pathology report for TSTs.

**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.

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

All IGRA test results should be documented in their unit of measurement, even for those with negative or indeterminate results. Pathology reports should be uploaded into eMedical or attached to the paper file.

**Results of the TB test and what to do next**

Where the TST is > 10mm (or > 5mm if there has been close household contact within the last five years) or there is a positive IGRA (or where clinical examination is suggestive of TB), a CXR is required.

In children aged 10 years and under, a standard PA projection is required as well as lateral view (510 examination). A lateral view is not required for applicants aged 11 years and over.

If the CXR is normal and there are no other clinical signs then the Panel Physician should ‘B’ grade the case.

If the CXR shows signs consistent with active TB, then sputum testing and pulmonologist (preferably paediatric) review are both immediately required.

All these cases should be ‘B’ graded.

**Refusal to undertake IGRA and TST**

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 applicant should not be offered CXR (502 and 510 examinations) as an alternative.

**Indications for additional testing and Management of LTBI**

Regardless of visa category, all children under the age of five who are either close household contacts of active TB within the last five years, or who have a positive 719 examination, should be referred for CXR examination and specialist paediatric review.
Treating doctors should have a low threshold for commencing treatment for LTBI, once active TB has been excluded.

The only exception to this is for close contacts of cases confirmed to be multi or extensively drug resistant (MDR or XDR) TB. Prophylactic treatment of LTBI in these cases is complex and may best be managed after the child arrives in Australia.

Commencement of prophylactic treatment for LTBI, should not delay submission of the case to the Department. All these cases should be B graded and comment should be made indicating close household contact with active TB and prophylactic treatment for LTBI has/has not commenced.

39. Diagnostics

Sputum testing

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

- Haemoptysis, or
- any infectious or post infectious x-ray changes in a person who has clinical signs or symptoms of TB, or
- any infectious or post infectious X-ray change in an HIV positive or otherwise immunocompromised person, or
- radiological findings which indicate a strong suspicion of active TB
  - in adults, such findings include cavitation, soft infiltration or large effusion
  - in children, any infiltrate or subtle finding 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 MOC in Australia. If Panel Members believe specialist referral and sputum testing is indicated, but they are technically unable to add a 603 examination, they should contact the Department 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 sputum 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.

Panel Members should maintain Standard Operating Procedures (SOPs) specific to sputum collection requirements for migrant health cases.

Administrative arrangements

1. Information must be provided to the applicant prior to attendance in respect of time of attendance (first thing in the morning) and they must not have breakfast or clean their teeth.
2. On attendance, confirm the identity of the applicant.
3. Ensure the applicant is fasting.
4. Explain the collection procedure to the applicant.
5. Use appropriate disposable equipment.

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 and within a week, in the early morning. Sputum must be collected directly observed in an appropriate and safe area as outlined above with standard operating procedures in place such as following mouth rinsing with saline solution, distilled or purified water. Check that sputum is collected, not just saliva.

The collector, supervisor of the laboratory or laboratory technician preparing the specimen should 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 their mouth between coughs. All applicants need to be instructed to take three deep breaths, and on the forth deep breath, 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 considered 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. Water used for mouth-rinsing must not be tap water. It should be distilled or bottled. Large water cooler dispensers are not suitable as there is increased risk of contamination.

**Instructions for applicants**

1. Rinse mouth with water and spit out.
2. Cover mouth with a tissue.
3. Sit on the stool provided.
4. Hold the collection cup and take the top off.
5. 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.
6. Hold your arm around your stomach and cough deeply.
7. Collect the sputum in your mouth.
8. Gently spill the sputum into the cup.
9. Put the top on the cup and seal shut.
10. Give the container to the staff in attendance.

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

Visual aids including posters or video demonstrations of collection techniques are strongly recommended to assist applicants with providing an adequate specimen.

**Sputum collection in children**

It is recognised that children under eight years of age may have difficulty in producing sputum. Applicants 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.

**Use of induced sputum**

Nebulised saline induction can be utilised especially for applicants 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 applicant 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, applicants may claim that they are unable to produce three separate sputum samples. It is worth remembering that Australian regulations stipulate that the applicant must be free of TB prior to entry to Australia, and the onus is on the applicant 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 applicant 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 separate in its own collection container at all stages of the process, including when specimens are being cultured.

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 as detailed below.

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

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 mode of 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 if 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.

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 fields), 1+ (1-9 per 10 fields) or if less than 1-2 per 30 fields – the exact number seen.

For both, if no AFB is seen, the recording is zero.

**Sputum 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) if available.

**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.

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 molecular tests may use them for faster identification but not as a culture substitute for health clearance purposes. Drug susceptibility testing must always be done to confirm sensitivity patterns.

Molecular tests should be used in the following situations:

- smear positive applicants, to allow early identification of possible drug resistance and to assist in differentiating non-tuberculous mycobacteria from MTB
- treatment relapse, that is, suspicion of drug resistance
- any case where there is a strong suspicion of active TB
- situations where there is suspicion of pre-treatment, that is, where applicants may be self-treating with anti-tuberculous medication prior to sputum collection.
Molecular testing is only required on one specimen and not all three sputum specimens.

**Submitting Results and TB alerts**

Sputum testing results should be submitted along with any specialist report and the repeat CXR. This should generally occur after three months, if negative. If treatment has been recommended then results should be submitted immediately so that the Department is aware.

Routine TB alerts are not required for electronic cases if the results are submitted in a timely manner. The Department only needs to be alerted to the following situations:

- multi–drug resistant or Extensively Drug Resistant TB
- applicants who default on treatment or where there is treatment failure
- where the Panel Physician becomes aware of a diagnosis of TB after the applicant’s case has been finalised
- active TB cases (smear, culture or molecular test positive) cases managed on paper (not using eMedical) where the Department is not aware that TB investigation is underway, for example, where the Panel Physician, not the MOC, has initiated TB investigation.

Alerts should be submitted using the Contact Us tab in eMedical. For clinics not using eMedical the Panel Physician Enquiry Form (PPEF) should be used or email the Department at health@homeaffairs.gov.au.

The subject line must include the title: *Notification of Active TB case – HAP ID: xxxxxx, ‘Medical–in–Confidence’.*

Details required for notification of such cases are:

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

Panel Physicists should notify the Department even if the applicants indicate that they are withdrawing from the visa process.

### 40. 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. Suitably qualified and experienced Panel Physicians may, depending on local regulations, not need to refer applicants to
external specialists for TB treatment and they are permitted to manage the applicants directly. In these cases, there should be a low threshold for referral to a chest specialist, for example, if the diagnosis is not microbiologically proven, the applicant does not accept the diagnosis, or complications develop. All drug resistant cases should be referred for specialist opinion.

Clinicians 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. These should be in the minority if good sputum collection techniques and high quality laboratories are used.

**Isolation of applicants**

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

- symptomatic presentation that is highly consistent with pulmonary TB
- smear-positive PTB
- infectious applicants with infants or immune-compromised family contacts
- applicants 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, applicants 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. Those with MDR cases should wear facemasks until culture conversion has been documented as above. Applicants 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, applicants should be educated in additional means of reducing transmission risk, including household isolation or other means of minimising family or social contact.

**Treatment**

Internationally recognised guidelines for treatment include those published by the World Health Organization, the American Thoracic Society (ATS), Center 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 Case 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**: [https://www.cdc.gov/tb/default.htm](https://www.cdc.gov/tb/default.htm)

Treatment of TB disease should occur in compliance with international standards and in cooperation with National Tuberculosis Programs wherever possible. Whilst it is understood that in some countries patients must be referred to NTPs for treatment, Panel Physicians must counsel applicants that health clearance for the purposes of the IME requires them to demonstrate that they are free of TB. This health clearance will only be provided if documentation demonstrates they are cured. Further information about this is provided below.

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 when drug susceptibility testing results are available.
Directly Observed Therapy (DOT)

Treatment must be delivered as DOT. DOT is an adherence-enhancing strategy in which a health-care 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 increases the likelihood that the applicant will be cured of TB.

If the applicant is 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 the laboratory associated with the panel clinic.

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 Australia.

The eMedical TB treatment forms (607 examination) should be filled out by Panel Physicians, regardless of whether a chest specialist report is provided. The 607 examination mandates the level of detail required. Additional documents such as the DOT record should be attached.

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 should treat MDR-TB according to internationally recognised guidelines.

Treatment monitoring in MDR-TB 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 MDR-TB also increase potential for stigmatisation and other negative psycho-social responses to treatment.

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

CXRs 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.

Applicants 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 applicants taking cycloserine, for which depression and psychosis are known potential side-effects.

All cases identified with drug resistance are reviewed by an expert panel in Australia. This takes place at the completion of treatment and after the Department has received the case file. This expert panel also reviews cases where applicants were treated for drug resistant TB prior to the IME. This process is managed by the Department and Panel Physicians play no part. The expert panel provides advice about whether the applicant can be considered free from TB.

If treatment provided is considered to have been inadequate, there is no evidence provided to support the treatment regimen administered, there is inconsistent advice, or there are incomplete records, the expert panel may recommend further surveillance in the applicant’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 applicant advises that they wish to withdraw from this process, the Panel Physician should then finalise the case as “incomplete” indicating this.
Monitoring during treatment

CXR 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. 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.

If any CXRs are taken during treatment, they do not need to be uploaded into eMedical or provided to the Department in hard copy (for paper cases). However, a CXR is required at the end of treatment and this must be submitted to the Department.

Laboratory monitoring during and after TB treatment.
Sputum testing during treatment (that is, in-treatment monitoring), even if that treatment is being provided through a different facility, is required.

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

Children aged nine years and under with pan-susceptible or culture-negative TB who cannot provide sputum specimens do not need to provide induced sputum or gastric aspirate specimens during treatment, unless their clinical course warrants an evaluation.

Pan-susceptible cases
For pan-susceptible cases, 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 specimens should be collected at the end of therapy if the applicant’s treatment is not being provided by DOT at a panel clinic.

Resistant to only one drug
Cases resistant to only one drug, including resistant to only isoniazid or rifampicin, require 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
For cases 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 cases
MDR-TB cases (resistant at least to both isoniazid and rifampicin) require 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.

Culture negative cases
For no drug susceptibility testing results (culture negative cases), 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.

Ongoing monitoring
Panel Physicians who are not providing TB treatment directly must continue to monitor applicants throughout their treatment at least monthly. Where this treatment is undertaken with external providers, Panel Physicians should foster close ties with the treating physicians and liaise regularly so as to identify and resolve problems or issues that may arise. It is recommended that Panel Physicians provide written guidance to treating physicians in relation to our requirements. Please refer to the below points for further information and guidance.

- minimum baseline investigations recommended (if not already performed)
- minimum treatment monitoring requirements (including weight)
- 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.

At the end of treatment, the following is required:

1. CXR and end of treatment sputum testing (if indicated, see above).
2. Clinical review (this includes review of serial CXRs, DOT records, sputum testing results and any specialist reports).

The following documentation, at minimum should be submitted in eMedical or attached to the paper case:

1. All treatment records including the DOT record.
2. All sputum test results.
3. End of treatment CXR.
4. Report from the final clinical review.

Please note that the 607 examination must be completed which should assist Panel Physicians in ensuring sufficient level of details are provided.

Health Clearance at end of Treatment

The MOC provides the final opinion about whether the applicant can be considered free of TB. Panel Physicians submitting records confirming that applicants were treated according to the Instructions. Sputum processing and treatment should be conducted using an approved laboratory or clinic in specified countries (see Appendix D for complete list), with appropriate clinical oversight, and with DOT provided by a health care worker, should expect to receive a health clearance in a timely manner.

Panel Physicians who are unable to provide such records, for example, if the applicant was treated at an external provider, should advise applicants that their health clearance will be deferred for a minimum period of 12 months from the end of their treatment. At that time, new health examinations will be required, including repeat sputum testing. This process is set in place to ensure early identification of drug resistant TB, which is always a risk when treatment provided has not been adequately supervised.

It is vital that Panel Physicians make clear on any reports, and/or in the 607 examination, whether the treatment was undertaken at the panel clinic or its affiliated TB management facility, or whether the treatment was undertaken in an external facility which is not affiliated with the panel clinic.

Please refer to Appendix D of these Instructions for the list of Approved TB Laboratories and DOT Centres. Panel Physicians or clinics based outside the countries listed in Appendix D would usually have been notified by the Department about which laboratories and treatment facilities are suitable for Australian visa applicants. If in doubt, please contact the Department.
41. Contact Tracing

Index case
For IME purposes, tracing of contacts who are also visa applicants must be undertaken where there is a current confirmed case of active TB identified.
Contacts of persons with pulmonary TB disease should be removed.

Which contacts should be traced
Contacts are defined as those with intimate or prolonged interaction 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 IME setting should be focused on contacts 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 visa applicants who are contacts include TST or IGRA. If the TST or IGRA is negative, then this test should be repeated eight weeks after exposure ends.
If TST or IGRA is positive, then the contact should be further evaluated. This evaluation includes medical history, physical examination, and CXR if not already undertaken.
Sputum testing or specialist review may be indicated. The following diagram shows the decision process for evaluating contacts, if visa applicant, of confirmed TB cases.
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 IME setting, this should occur after the applicant arrives in Australia and not be initiated by Panel Physicians. However, if the applicant decides to undergo LTBI treatment, this can be initiated in the country of origin, but the applicant should understand that this treatment cannot be discontinued or interrupted once started, unless directed otherwise by the treating physician. Upon arrival in Australia, the applicant 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 applicant's home country such as:

- children who are immunocompromised
- children aged four years and under 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 asymptomatic applicants who are 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.

42. Notification

Notification of local public health authorities

When an active TB case is identified during the IME, Panel Physicians should communicate with the local public health authority as directed by their jurisdiction. The intention behind this practice is 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 the Department
- improve notification and reporting rates within the National TB Programme.

Post-arrival medical follow up

Panel Physicians should introduce the notion of a mandatory medical follow-up to the applicant if and when their visa application is approved. Once the decision is rendered and admissibility is granted, the applicant 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.
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 applicant by others, the effects it may have on resettlement, and the difficulties that treatment may present. This can be particularly so for applicants 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 have trouble accepting the diagnosis. TB is also associated with lower socio-economic groups, meaning diagnosis may be further resisted in cohorts from higher socio-economic backgrounds.

Addressing the psycho-social impacts of TB diagnosis and treatment forms an important part of TB management. In particular, applicants 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 applicants identified as requiring TB treatment as indicated above. They should be reassured that TB can be treated. 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 applicant during treatment and observe for physical or psychological deterioration. To improve well-being, addressing diet, smoking habits or substance abuse should be promoted.

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

Any applicants 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 applicant’s mental state.

Counselling should be made available on a weekly basis to all applicants who wish to utilise this service. Counselling should address applicants’ thoughts and feelings about their TB diagnosis and treatment, perceptions of stigma or discrimination experienced by others, and factors that may affect their adherence to treatment.

2 Acknowledgement is provided to International Organization for Migration on whose guidelines Appendix A and B have been adapted.
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.

Applicants 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 applicants taking Cycloserine as depression, suicidal thoughts and psychosis are known side-effects. All applicants 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 applicants in prolonged isolation and family visits managed in order to ensure ongoing contact without unnecessary cross-infection risk. Applicants 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 applicant 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 applicant condition, including recognising mental changes and warning signs. Personnel should understand the need to listen and respond to individual 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 applicants and staff requires:

- awareness of transmission and the need for infection control
- cough etiquette and respiratory hygiene
- 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 applicants, 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. Applicants should be routinely asked about cough on entering the facility. Applicants 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 laboratory. 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 applicants when working.

UV lights can also be used for cleaning air and surfaces, but these cannot be operated whilst staff or applicants 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 applicants

All applicants 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. They should be shown how to correctly fit these, and educated about the importance of wearing masks until they become non-infectious.
These applicants should be managed separately 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 applicants’ 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 applicants should wear P2/N95 respirator masks 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. Masks should not be touched while being worn and hand hygiene should be performed upon touching and disposing of a used mask.

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

Staff exposed to infectious or potentially infectious applicants 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 applicants 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**
   - <10mm → **Grade A**
   - ≥10mm* → **CXR (PA and lateral) 502 & 510**
     - ≥5 mm in close household contacts → Abnormal
     - Normal → **Grade B** with comment

2. **719 TB Test**
   - Positive → Abnormal
     - Not consistent with TB and no clinical findings → Refer paediatrician review
     - Sputum Testing and refer to pulmonologist or paediatrician, sputum testing / gastric aspirate
     - Consistent with TB and clinical findings OR strong suspicion of active TB → Grade B
   - Indeterminate → Repeat test not required Grade B with comment
   - Negative → **Grade A**

3. **IGRA**
   - Indeterminate
   - Negative → **Grade A**
### Appendix D: Approved TB Laboratories and DOT Centres

All Panel Members in the specified countries must use the approved TB laboratory for sputum processing. This list is under development and Panel Members will be advised of updates or changes for their country.

<table>
<thead>
<tr>
<th>Country</th>
<th>City</th>
<th>Laboratory</th>
<th>DOT Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Dhaka</td>
<td>IOM Dhaka</td>
<td>IOM Dhaka</td>
</tr>
<tr>
<td>Beijing</td>
<td></td>
<td>Beijing ITHC</td>
<td>Beijing ITHC</td>
</tr>
<tr>
<td>Chengdu</td>
<td></td>
<td>Chengdu IME Centre/ Chengdu Western Hospital</td>
<td>Chengdu IME Centre</td>
</tr>
<tr>
<td>Fuzhou</td>
<td></td>
<td>Fujian Provincial Hospital (South Branch)</td>
<td>Immigration Medical Centre - Fujian Provincial Hospital</td>
</tr>
<tr>
<td>Guangzhou</td>
<td></td>
<td>Guangdong ITHC</td>
<td>Guangdong ITHC</td>
</tr>
<tr>
<td>Jinan</td>
<td></td>
<td>Jinan IME Centre - Second Hospital of Shandong University</td>
<td>Jinan IME Centre - The Second Hospital of Shandong University</td>
</tr>
<tr>
<td>Shanghai</td>
<td></td>
<td>Shanghai ITHC</td>
<td>Shanghai ITHC</td>
</tr>
<tr>
<td>Shenyang</td>
<td></td>
<td>Shenyang IME Centre/LEPC Hospital</td>
<td>Shenyang IME Centre</td>
</tr>
<tr>
<td>Shenzhen</td>
<td></td>
<td>IME Centre – Shenzhen</td>
<td>IME Centre – Shenzhen</td>
</tr>
<tr>
<td>Wuhan</td>
<td></td>
<td>Hubei ITHC</td>
<td>IME Centre-Wuhan-Hubei ITHC.</td>
</tr>
<tr>
<td>Chongqing</td>
<td></td>
<td>Infectious disease/Chest Hospital</td>
<td>Infectious disease/Chest Hospital</td>
</tr>
<tr>
<td>Xi’an</td>
<td></td>
<td>Xi’an Tuberculosis and Chest Tumor Hospital</td>
<td>Xi’an Tuberculosis and Chest Tumor Hospital</td>
</tr>
<tr>
<td>Hangzhou</td>
<td></td>
<td>ITHC Shanghai</td>
<td>Immigration Medical Unit Hangzhou Hailiao Medical Examination Centre</td>
</tr>
<tr>
<td>Nanjing</td>
<td></td>
<td>ITHC Shanghai</td>
<td>ITHC Shanghai/ Nanjing Raffles</td>
</tr>
<tr>
<td>Harbin</td>
<td></td>
<td>Shenyang IME Centre/LEPC Hospital</td>
<td>Harbin IME Centre - Heilongjiang International Travel Healthcare Centre</td>
</tr>
<tr>
<td>Egypt</td>
<td>Cairo</td>
<td>Dr Shahira Gemie Gemie Lab</td>
<td>IOM Cairo</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Addis Ababa</td>
<td>International Clinical Laboratory</td>
<td>IOM Addis Ababa</td>
</tr>
<tr>
<td>Ahmedabad</td>
<td></td>
<td>Apollo Hospitals International Ltd</td>
<td>APHC block, Apollo hospitals</td>
</tr>
<tr>
<td>Country</td>
<td>City</td>
<td>Laboratory</td>
<td>DOT Centre</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>India</td>
<td>Bangalore</td>
<td>SRL Diagnostics</td>
<td>Elbit Diagnostic Centre; Fortis Hospital</td>
</tr>
<tr>
<td></td>
<td>Chandigarh</td>
<td>SRL Chandigarh</td>
<td>National Medical and Dialysis Centre</td>
</tr>
<tr>
<td></td>
<td>Chennai</td>
<td>Apollo Hospitals</td>
<td>Apollo Hospitals</td>
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<tr>
<td></td>
<td>Hyderabad</td>
<td>Vijaya Diagnostics</td>
<td>Centre for Migration Medicine (CMM); GYD Diagnostics and Clinics</td>
</tr>
<tr>
<td></td>
<td>Kolkata</td>
<td>SRL Religare</td>
<td>Pulse Diagnostics Pvt Ltd</td>
</tr>
<tr>
<td></td>
<td>Ludhiana</td>
<td>SRL Ludhiana</td>
<td>Dr Wahiguru Pal AND Dr Harkamal Bagga; Satguru Partap Singh (SPS) Hospital</td>
</tr>
<tr>
<td></td>
<td>New Delhi</td>
<td>SRL Gurgaon</td>
<td>Max Multi Speciality Centre; Sadhu Vaswani Mission Medical Centre</td>
</tr>
<tr>
<td></td>
<td>Mumbai</td>
<td>Lilavati Hospital Laboratory</td>
<td>Lilavati Hospital &amp; Research Centre; Rele Clinic AND Insight Health Scan</td>
</tr>
<tr>
<td></td>
<td>Mohali</td>
<td>SRL Chandigarh</td>
<td>Kansal Clinic; Max Super Speciality Hospital</td>
</tr>
<tr>
<td></td>
<td>Trivandrum</td>
<td>Amrita Institute of Medical Sciences and Research Centre, Kochi</td>
<td>KIMS Trivandrum</td>
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<tr>
<td></td>
<td>Pune</td>
<td>Lilavati Hospital laboratory</td>
<td>Ruby Hall Clinic</td>
</tr>
<tr>
<td></td>
<td>Denpasar</td>
<td>Sanglah Hospital</td>
<td>BIMC Hospital</td>
</tr>
<tr>
<td></td>
<td>Jakarta</td>
<td>Fakultas Kedokteran Universitas Indonesia (FKUI aka Micro-UI)</td>
<td>IOM MHAC Unit (Refugee visa applicants only); Premier Bintaro Hospital; RS Premier Jatinegara Hospital</td>
</tr>
<tr>
<td></td>
<td>Makassar</td>
<td>NHCR Hasanuddin University Medical Research Center</td>
<td>Siloam Hospitals Makassar IOM (Refugee visa applicant only)</td>
</tr>
<tr>
<td></td>
<td>Medan</td>
<td>RS Adam Malik (Government Hospital)</td>
<td>Dr. Tunggul Hutapea; IOM (Refugee visa applicants only)</td>
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<tr>
<td></td>
<td>Semarang</td>
<td>BalaiLaboratoriumKesehatan</td>
<td>St Elisabeth Hospital</td>
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<td>Country</td>
<td>City</td>
<td>Laboratory</td>
<td>DOT Centre</td>
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<tr>
<td>Kenya</td>
<td>Surabaya</td>
<td>BalaiBesarLaboratoriumKesehatatan (BBLK)</td>
<td>RS Premier Surabaya</td>
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<tr>
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<td>IOM Nairobi</td>
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<td>IOM Kathmandu</td>
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<td>Damak</td>
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<td>IOM Damak</td>
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<tr>
<td></td>
<td>Davao</td>
<td>St Luke’s Extension Clinic, Manila</td>
<td>Nationwide Health Systems Davao Inc</td>
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<tr>
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<td>Cebu</td>
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<td>Nationwide Health Systems Baguio Inc</td>
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<td>Sri Lanka</td>
<td>Colombo</td>
<td>National TB Reference Laboratory</td>
<td>IOM Colombo</td>
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<tr>
<td>Thailand</td>
<td>Bangkok</td>
<td>IOM Bangkok</td>
<td>IOM Bangkok</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Bangkok General Hospital</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Bangkok Nursing Home</td>
</tr>
<tr>
<td></td>
<td>Chiang Mai</td>
<td>IOM Bangkok</td>
<td>Chiang Mai Ram Hospital</td>
</tr>
<tr>
<td></td>
<td>Phuket</td>
<td>IOM Bangkok</td>
<td>Bangkok Hospital Phuket</td>
</tr>
<tr>
<td></td>
<td>Mae Sot(Refugee only)</td>
<td>IOM Mae Sot</td>
<td>IOM Mae Sot</td>
</tr>
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<td></td>
<td>IOM Mae Hong Son (Refugee only)</td>
<td>IOM Mae Hong Son</td>
<td>IOM Mae Hong Son</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>Dili</td>
<td>National TB Reference Laboratory</td>
<td>Stamford Medical</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Ho Chi Minh City</td>
<td>Cho Ray Hospital</td>
<td>Cho Ray Hospital</td>
</tr>
<tr>
<td></td>
<td>Hanoi</td>
<td>Through IOM Hanoi</td>
<td>Through IOM Hanoi</td>
</tr>
</tbody>
</table>
Appendix E: Undressing for a Medical Examination

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>
<tbody>
<tr>
<td>Arthritis</td>
<td><strong>‘A’ Grade:</strong> Minor disease - no interference with function. &lt;br&gt;<strong>‘B’ Grade:</strong> 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. &lt;br&gt;Perform functional assessment and document treatment requirements. Specialist report not required unless considered appropriate and requested.</td>
</tr>
<tr>
<td>Back pain</td>
<td><strong>‘A’ Grade:</strong> No functional impairment. &lt;br&gt;<strong>‘B’ Grade:</strong> ADL’s and/or work capacity impaired. Perform functional assessment and provide treatment details. Specialist report may be requested.</td>
</tr>
<tr>
<td>BMI – body mass index</td>
<td><strong>‘A’ Grade:</strong> Stable weight, or obesity without complications &lt;br&gt;<strong>‘B’ Grade:</strong> Unexplained weight loss, or obesity with complications known or suspected. Provide details, relevant test results, and estimation of treatment needs.</td>
</tr>
<tr>
<td>Cancer</td>
<td><strong>‘A’ Grade:</strong> No recurrence ≥ five years post-treatment, with no symptoms or ongoing functional impairment &lt;br&gt;<strong>‘B’ Grade:</strong> New diagnosis, recurrence exists, or if &lt; five years since treatment. Recent specialist report within the last 12 months required.</td>
</tr>
<tr>
<td>Cardiac murmur</td>
<td><strong>‘A’ Grade:</strong> Asymptomatic, healthy applicant with normal X-ray where pathology has been excluded. &lt;br&gt;<strong>‘B’ Grade:</strong> Symptomatic or evidence of cardiac failure. Cardiology opinion and echocardiography required.</td>
</tr>
<tr>
<td>Chest X-ray changes</td>
<td><strong>‘A’ Grade:</strong> Anatomical variations and benign changes. &lt;br&gt;<strong>‘B’ Grade:</strong> All pathological, infectious, or post-infectious changes.</td>
</tr>
<tr>
<td>Diabetes</td>
<td><strong>‘A’ Grade:</strong> If stable with no suspicion or evidence of end-organ damage. &lt;br&gt;<strong>‘B’ Grade:</strong> 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.</td>
</tr>
<tr>
<td>Frail elderly</td>
<td><strong>‘A’ Grade:</strong> Reasonably fit with no cognitive or functional impairment. &lt;br&gt;<strong>‘B’ Grade:</strong> Evidence of cognitive or functional impairment. MMSE/ ADL assessment required. Document medical issues and treatment needs.</td>
</tr>
<tr>
<td>Hearing loss</td>
<td><strong>‘A’ Grade:</strong> Reasonable hearing with or without hearing aids. &lt;br&gt;<strong>‘B’ Grade:</strong> 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.</td>
</tr>
<tr>
<td>Condition</td>
<td>Approach</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hepatitis B Surface antigen positive</td>
<td><strong>‘B’ Grade in all cases:</strong> Perform LFT’s and Hepatitis C test. Complications or abnormal liver function test results require gastroenterology assessment including ultrasound and/or fibroscan.</td>
</tr>
<tr>
<td>Hepatitis C positive</td>
<td><strong>‘B’ Grade in all cases:</strong> 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><strong>‘B’ Grade in all cases</strong> once confirmatory assay (Western blot/immunoblot) result is available. If not available, retest with different EIA method to original test. If on treatment, request report from treating specialist and perform Hepatitis C test. If not treated, obtain CD4 count, viral load and specialist physician review.</td>
</tr>
<tr>
<td>Hypertension</td>
<td><strong>‘A’ Grade:</strong> Stable with no evidence of end-organ involvement. <strong>‘B’ Grade:</strong> 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>Intellectual disability</td>
<td><strong>‘B’ Grade in all cases:</strong> Document nature and degree of disability. Perform developmental age assessment in children and young adults. Consider specialist assessment.</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td><strong>‘A’ Grade:</strong> Stable and asymptomatic. <strong>‘B’ Grade:</strong> If unstable or symptomatic, refer for cardiology assessment</td>
</tr>
<tr>
<td>Latent TB Infection</td>
<td><strong>‘A’ Grade:</strong> TST &lt; 10mm or IGRA negative. <strong>‘B’ Grade:</strong> TST ≥ 10mm, IGRA positive or indeterminate, and all close household contacts of index cases no matter the result of LTBI test.</td>
</tr>
<tr>
<td>Neurological disorders (for example, MS)</td>
<td><strong>A Grade:</strong> Minor sequelae of previous disease (for example, deformity from childhood polio) that has no significant functional impairment <strong>B Grade:</strong> 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><strong>‘A’ Grade:</strong> Mild, without restriction on daily living or employment capacity. <strong>‘B’ Grade:</strong> 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. <strong>‘A’ Grade:</strong> X-ray is available and normal, or applicant is from lower risk country <strong>‘B’ Grade:</strong> No X-ray is available in applicants from higher risk countries (cases should generally be deferred until CXR is available)</td>
</tr>
</tbody>
</table>

Australian Panel Member Instructions
July 2020
<table>
<thead>
<tr>
<th>Condition</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psoriasis</td>
<td>‘A’ Grade: Skin involvement only</td>
</tr>
<tr>
<td></td>
<td>‘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</td>
</tr>
<tr>
<td></td>
<td>‘B’ Grade: If past surgery impacts current health or function or further surgery is required.</td>
</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 (e.g., “fibrosis” on CXR)</td>
<td>‘B’ Grade in all cases: Submit medical file without sputum collection.</td>
</tr>
<tr>
<td>Thyroid</td>
<td>‘A’ Grade: All benign thyroid disorders</td>
</tr>
<tr>
<td></td>
<td>‘B’ Grade: If malignancy known or suspected. In that case, further investigation such as an ultrasound and/or specialist report required.</td>
</tr>
<tr>
<td>Urine abnormalities</td>
<td><strong>The grade will be auto-managed by eMedical. For paper cases:</strong></td>
</tr>
<tr>
<td></td>
<td>‘A’ Grade: repeat urinalysis is normal and/or red cells less than 10 x 10⁶/L red blood cells, or isolated glycosuria with no other evidence of end-organ disease.</td>
</tr>
<tr>
<td></td>
<td>‘B’ Grade: all other urinary abnormalities.</td>
</tr>
<tr>
<td>Visual impairment</td>
<td>‘A’ Grade: VA &gt; 6/24 in better eye (with use of corrective lens or pinhole).</td>
</tr>
<tr>
<td></td>
<td>‘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.</td>
</tr>
</tbody>
</table>
## 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>Age</th>
<th>Gross motor/fine motor milestones</th>
<th>Social/speech/communication milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 weeks</td>
<td>- Eyes mostly moving together&lt;br&gt;- Some head control—not loping everywhere&lt;br&gt;- Symmetrical movements of limbs</td>
<td>- Cooing (vowels) emerging&lt;br&gt;- Starting to smile (probably)&lt;br&gt;- Some brief eye contact</td>
</tr>
<tr>
<td>4 months</td>
<td>- Hands to midline and then to mouth&lt;br&gt;- Has hand regard&lt;br&gt;- Lifts knees&lt;br&gt;- Tracks objects through 180 degrees&lt;br&gt;- Lifts head up 90 degrees when lying prone&lt;br&gt;- Grasps objects handed to him or her</td>
<td>- Cooing well established&lt;br&gt;- Social smiling (smiling in response to a smile) and laughs&lt;br&gt;- Eye contact more prolonged at times&lt;br&gt;- Babble (consonants) emerging (possibly)</td>
</tr>
<tr>
<td>6 months</td>
<td>- Propped up sitting (independent sitting 7-8 months)&lt;br&gt;- Hands down in front of him or her, hands to feet&lt;br&gt;- Keeping head level with body when pulled to a sitting position&lt;br&gt;- Rolling-up on extended arm when placed in prone and creeping when placed in prone&lt;br&gt;- Possibly bangs objects on a surface</td>
<td>- Babbling well established&lt;br&gt;- Initiates and attends when spoken to (listening)&lt;br&gt;- Vocal play—experimenting with new sounds (e.g. blowing raspberries)&lt;br&gt;- Enjoys interactive games&lt;br&gt;- Smiles when sees parent&lt;br&gt;- Laughs/squeals with delight</td>
</tr>
<tr>
<td>12 months</td>
<td>- Takes weight on feet when feet plunked on ground in standing position (parachutes them) or standing holding onto furniture&lt;br&gt;- Transitions by moving in and out of positions&lt;br&gt;- Crawling (probable) and crawling&lt;br&gt;- Points and follows a point (possibly)&lt;br&gt;- Grasps with index and thumb&lt;br&gt;- Claps hands&lt;br&gt;- Waves goodbye</td>
<td>- Lots of conversational babble&lt;br&gt;- A couple of words (Mum, Dad, other) probably&lt;br&gt;- Possible separation and/or stranger anxiety&lt;br&gt;- Looks for objects out of direct line of vision (dropped toy)&lt;br&gt;- Co-looks at pictures in books or objects (shared attention)&lt;br&gt;- Possible pointing or following a point (look at the … ?)&lt;br&gt;- Waves bye-bye</td>
</tr>
<tr>
<td>18 months</td>
<td>- Walks well and probably holding hand upstairs&lt;br&gt;- Climbs on and off everything&lt;br&gt;- Exempts a jump&lt;br&gt;- Isolated ‘tip to tip’ pincer&lt;br&gt;- Bilateral play—hands doing different things&lt;br&gt;- Eyes point, focus and track a moving object&lt;br&gt;- Picking objects into containers</td>
<td>- Follows 1-step commands (when he or she wants to)&lt;br&gt;- Does pretend play—ies, sets, dolls, kitchen toys&lt;br&gt;- Interested in everything, especially people&lt;br&gt;- Pointing and following a point well established&lt;br&gt;- Good understanding of what is said, maybe developing lots of words (or soon)&lt;br&gt;- Points to body parts&lt;br&gt;- Uses at least 2 words by 16.5 months</td>
</tr>
<tr>
<td>3.5-4 years</td>
<td>- Moves towards learning to ride a bike&lt;br&gt;- Catches a ball onto chest&lt;br&gt;- Catches a larger ball with the hands&lt;br&gt;- Throws a ball overarm&lt;br&gt;- Hops&lt;br&gt;- Washes and dries hands&lt;br&gt;- Does puzzles independently</td>
<td>- Clear and intelligible speech&lt;br&gt;- Able to have a long reciprocal (back and forth) conversation with parents and siblings/peers&lt;br&gt;- Plays with siblings/peers&lt;br&gt;- Unwanted behaviours not standing out among peers (e.g. childcare, preschool)</td>
</tr>
</tbody>
</table>
# Appendix H: Activities of Daily Living (ADL) Assessment (903 examination)

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

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

<table>
<thead>
<tr>
<th></th>
<th>Full</th>
<th>Moderate</th>
<th>Minimal</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Comprehension</td>
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<tr>
<td>Expression</td>
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<td>☐</td>
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<tr>
<td>Social cognition</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Social interaction</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Memory</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

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): ____________________________