Australian Government
Department of Home Affairs

Australian Panel Member Instructions

Immigration Medical Examinations

July 2024

Issued by the Department of Home Affairs
Australia, July 2024

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 Physicians 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. These instructions are also available under the eMedical support tab (under 'Australia Specific' documents).

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 Instructions are available in an electronic format in the Panel Physician Gateway on the Department's website at: Conducting Australian visas Medical (homeaffairs.gov.au)

The Instructions are reviewed and updated periodically, and 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.

The Instructions do not provide technical advice relating to the use of eMedical. Panel Members must refer to the 'eMedical Support' tab for tip sheets and other supporting material.

1. Panel Management

1.1 The Department of Home Affairs

The Department manages the Australian Panel Physicians Network around the world, including:

- managing the number and location of panel clinics and Panel Members
- conducting audits to assess both quality and integrity of the work done by Panel Members
- 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 the IME requirements
- addressing all eMedical system related queries.

1.2 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.

eMedical system and IME related enquiries may 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.

See: https://immi.homeaffairs.gov.au/help-support/departmental-forms/online-forms/panel-physician-enquiry-form

The PPE form can be used for the following queries:

- 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, users at your clinic do not understand how to use part of the system, or you require help with uploading documents/removing incorrectly uploaded images/documents.
- Seeking 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 or approval required from the Department - for example, you need to advise the Department about a change in your clinic details or appoint a locum physician.
- Queries regarding membership of the Australian Panel Physicians 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 Panel Physician Enquiry form on the Department's website can contact the Department by email. Ensure the email includes your official signature block, full clinic name and clinic location. Queries relating to specific cases must include the applicant's Health Assessment Portal (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)
Website:	https://immi.homeaffairs.gov.au/help-support/tools/panel-physician-gateway
Courier:	Department of Home Affairs Attention: Mailroom Immigration Health Level 3, 101 George Street Parramatta NSW 2150 AUSTRALIA

Refer to instructions on the Department's website – 'Where to send Australian immigration medical results'

https://immi.homeaffairs.gov.au/help-support/tools/panel-physician-gateway/conducting-australian-visa-medicals

Note: For general visa and migration related enquiries please refer to the Department's website: https://immi.homeaffairs.gov.au/

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 the IME and Departure Health Check (DHC), and submit the results to the Department. The eMedical system is currently used by:

- the Australian Department of Home Affairs
- Immigration New Zealand
- Immigration Refugees and Citizenship Canada
- the United States of America (USA).

Australia, New Zealand, Canada and USA aim to achieve 100 per cent electronic processing of all IMEs globally. Therefore, all members of their respective Panel networks are expected to use the eMedical system where technically possible. Using the available electronic processing technology is a key requirement for membership 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)

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

3.1 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.

3.2 eMedical Roles

The Department can appoint an additional role in eMedical of 'Clinic Administrator' to the administrator at clinics. This level of access enables the Clinic Administrator to perform clinic administration tasks in eMedical without having to contact the Department. Clinic Administrators can manage individual user access (add, remove, or update eMedical user) and update clinic information (address, phone, email details etc.) as well as processing applicants.

Clinic administrators can also be granted Clerical (Medical) and/or Clerical (Radiology) access (depending on the services offered at the clinic) so that they have complete visibility of the clinic's eMedical operations and can support all eMedical users at the clinic. The Department recommends that each clinic has two Clinic Administrators as backups.

More information is available in eMedical under eMedical Support in Module 6 – Clinic Administration

3.3 My Health Declarations and multiple HAP IDs

Applicants sometimes present to clinics with multiple HAP IDs. In these cases, the clinic needs to confirm with the applicant whether they have already undertaken an Australian IME in the past 12 months.

If the applicant has completed their IME previously at the same IME clinic, provide them with a copy of the 'information sheet' available in eMedical in the Health Case Details page, which contains evidence that the IME was submitted. Advise the applicant to provide a copy of the information sheet to their Visa Processing Officer or visa business area. Alternatively, applicants can use their ImmiAccount to upload this information sheet to their visa application. This enables the Visa Processing area to re-use the health results, which prevents the applicant from having to repeat the IME unnecessarily.

If the applicant has not completed their IME within the last 12 months and has arrived at the clinic with two HAP IDs, select the HAP ID that is assigned to a visa application.

3.4 eMedical support

There is detailed supporting material, tip sheets, user guides and training material in the use of eMedical available on the 'eMedical Support' tab of the eMedical system.

Enquiries relating to eMedical may 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.

See: https://immi.homeaffairs.gov.au/help-support/departmental-forms/online-forms/panel-physician-enquiry-form

4. Australia's Immigration Medical Examination process

4.1 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 public health risk or a danger to the Australian community
- any disease or condition which, during the applicant's stay in Australia would be likely to:
    - result in a significant cost to the Australian community in the areas of health care or community services
    - prejudice the access of an Australian citizen or permanent resident to health care or community services already in limited supply.

The only medical condition that prevents the grant of a visa as prescribed in the *Migration Regulations* 1994 (the Regulations), 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 Australian 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 (until they are found to be free of active TB).

The success of this TB screening is reflected by 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, multidisciplinary TB services in the states and territories of Australia.

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

See: http://www.homeaffairs.gov.au/Trav/Visa/Heal

4.2 How to determine which examinations are required

Panel Members are not required to determine what examinations are required for visa applicants or non-migrating family members (who are not visa applicants but may also be required to undertake an IME), this is made by the Department. However in some cases, Panel Members may become aware of new health information or a change in circumstances at the time of the IME. It is the responsibility of the Panel Member to update health examinations in accordance with instructions. See eMedical User Guide Module 9 – Examinations, for further information on adding and removing exams in eMedical.

If Panel Members are concerned that the correct examination has not been requested, they may contact the Department to clarify what is needed. Alternatively, the applicant can contact the Department, if they have already submitted a visa application.

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

- type of visa
- intended length of stay and activities
- country of birth
- 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.

Note: *Applicants who have applied for a temporary visa but advise that they intend to apply for permanent residency, provided they consent to it, must be examined in the first instance according to the requirements for permanent visa applicants.*

For panel clinics using eMedical:

The applicant must provide their HAP ID, which must be used by the clinic 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. If the applicant does **not** have a HAP ID, refer to the *eMedical User Guide* Module 7 – Administrative Tasks.

For panel clinics not using eMedical:

The applicant must present their 'eMedical Referral Letter' provided by the Department. This letter will contain the applicant's HAP ID and a list of examinations required based on information provided by the applicant to the Department. An applicant must only be given an appointment once they confirm possession of this letter and they must be reminded to bring the letter to their IME appointment.

4.3 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 who reach the 11 year-old age milestone) must be finalised in eMedical as incomplete with a note explaining the reason.

4.4 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.

MOCs employed by the Department's contracted Migration Medical Services Provider (MMSP) are located in Australia and assess Australian health cases submitted by Panel Members to provide an opinion about whether applicants meet Australia's immigration health requirement.

***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 required to complete an application for panel membership and satisfy minimum standards set by the Department. Panel Physicians outside of Australia must submit supporting documentation specified in the application form, including a copy of their primary medical degree and a detailed resume. All documentation submitted requires certified English translations, if the documents submitted are not in English. Panel Physicians outside of Australia are required to have a minimum of five years medical experience with a heavy focus on general physician skills.

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 MMSP, with whom the Australian Government has a contractual relationship.

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

Visa applicants may attend 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 responsibility for any costs associated with Panel membership, or loss of business or patronage at a clinic, as a result of:

- changes to the migration program
- applicants' choices
- additional clinics being empanelled in the same city, region and/or country to undertake IMEs
- suspension or cessation of Panel membership.

Required information with regard to the clinic facility must be provided to the Department. The decision to accept Panel membership 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/s and the panel site offered.

The Department prefers clinics that offer a combined experience (medical, radiology, pathology and preferably TB investigation and treatment all at one location), digital radiology and internet service to support eMedical. Clinics 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 virtual or physical 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. Although some aspects of the IME may be delegated to nursing or other staff, the Panel Member (a physician) retains responsibility for the overall process.

The number of Panel Members at a panel site must be commensurate with an optimum caseload for each member to maintain a desired level of experience and expertise in conducting IMEs without compromising quality or accuracy. The Department may from time-to-time request that panel clinics review the number of Panel Members to ensure this is maintained.

New Panel Members at existing panel clinics must undergo an orientation program that includes familiarisation with the Instructions, completion of online learning modules, 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.

5.1 Relocation of a Panel Member clinic

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

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

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

Panel membership, while attached to the individual Panel Member, is in association to a specific panel clinic and its physical location. This means that, unless confirmed by the Department, all memberships affiliated with a panel clinic will automatically cease upon an unapproved relocation of the clinic or if the Panel Member moves to an unapproved clinic. Any IME conducted by a Panel Member at an unapproved location will not be accepted, as their membership will not be valid.

5.2 Retirement or withdrawal of membership

The Department requests a **minimum of four weeks' notice** 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.

5.3 Suspension from the Panel

If the Department becomes 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 for Panel Members, 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 TB or 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 their 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 their panel membership.
- The Panel Member has failed to acknowledge or respond to repeat correspondence or requests for information from the Department.

In such cases, the Panel Member will be provided with a written notice of suspension, including the reason for suspension and given an 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 the Department suspends a Panel Member 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 panel membership may continue.

Where there are reasonable grounds to believe 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 may result in immediate removal from the Panel. Removal may also occur where the Panel Member brings the Australian Government into disrepute.

5.4 Removal from the Panel

Panel membership may be revoked at any time at the sole and absolute discretion of the Department. The decision to revoke membership is final and not subject to review. The Department will usually provide four weeks' notice before revocation takes effect. A shorter notification period may apply under some circumstances, such as where the Panel Member is already subject to 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 to the Department 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 made a decision to discontinue panel operations of a panel clinic, membership of all Panel Members at the site will cease.

5.5 Use of accredited laboratories

Blood specimens must **always** be collected at the panel clinic at the time of the IME, unless the Department has authorised approval for offsite pathology laboratories to be used where there is no alternative. To maintain integrity and prevent identity fraud, applicants must **not** be referred to a laboratory for the collection of these specimens.

Sputum samples for TB must be collected either at the panel clinic, chest clinic or at the TB laboratory where sputum processing will take place, provided the staff perform appropriate identity checking (for further instructions see the section on *Collection of Sputum* in Part D).

Laboratories used for processing sputum specimens for Mycobacterium tuberculosis (MTB) require specific expertise in this field. Panel Physicians must identify and use high quality accredited 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

Panel Members must ensure that the laboratories used for sputum testing have either:

- relevant International Organisation for Standardisation (ISO) accreditation
- the equivalent national or state accreditation in the country in which they are located
- are working towards that accreditation.

In the absence of accreditation, Panel Members are encouraged to use laboratories participating in the Strengthening Laboratory Management toward Accreditation (SLMTA).

Panel Members must be able to provide evidence of the above to the Department upon request (e.g. email confirmation from the laboratory, reference to laboratory's website etc.).

Panel Members are responsible for the selection of suitably accredited laboratories to perform HIV and other serological testing. Panel Members must 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, that in-date test-kits are used, and that applicants are never able to access their samples or coding information. Original laboratory reports must be provided to the Department (either uploaded 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 and on request by the Department.

5.6 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 examinations 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 the Department's 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.
- keep applicants updated about the progress of the examinations, particularly when these are delayed for any reason.
- if an unrecognised serious medical problem is discovered during the examination, inform the applicant or their treating doctor. Refer applicants requiring treatment to their usual treating physician, unless emergency treatment is required. Panel Physicians must make a note in eMedical regarding any verbal advice provided to the applicant or their treating doctor. If a Duty of Care letter is provided, a copy must be uploaded into eMedical. Refer to section 5.12 Disclosure of abnormal health conditions to applicants (Duty of Care) for further information.
- advise the Department of changes to the Panel Member's and/or panel clinic's contact details, schedule of fees charged to applicants, operating hours, working arrangements, clinic closures and Panel Members' 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. Applicant information should not be provided to any third party without the applicant's clear consent, with the consent being carefully verified before disclosure.

Panel Physicians are not:

- authorised to oversee IMEs conducted by non-Panel Members and must not outsource their services.
- 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 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 applicants for submission to Department under any circumstances.
- to give their eMedical account logon and password details to any other person.

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

5.7 The role of Chief Radiologist/Panel Radiologists

Every clinic that offers radiology services outside of Australia must have a Chief Radiologist, who must be a Panel Member. Chief Radiologists are required to have a minimum of five years' experience post completion of radiology training. The Chief Radiologist must provide evidence of their primary medical degree as well as specialty degree. The Chief Radiologist may nominate in writing any other radiologist/s for IME work, but the number of nominated radiologists must be limited to ensure that they have sufficient workloads 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 radiology 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. It is preferable for the Chief Radiologist to be located at the approved location for the majority 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 (CXRs) do **not** need to be permanently based onsite (although this is preferred) but must be located in the same country or time zone and 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 all nominated radiologists undertaking Australian immigration radiological examinations are suitably qualified and experienced as specialists 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 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 and any changes to these, including significant periods of closure or changes to operations 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 access to submit Australian cases can be granted.
- for paper cases, ensure that the CXR examination form and films are forwarded to the Panel Physician.
- ensure only empanelled radiologists conduct radiological examinations and report/grade or submit reports.
- 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 applicants and staff.
- ensure that all pregnant applicants taking a CXR are counselled about radiation risks and obtain the necessary consent and verify that the risks have been explained to the applicant.

- keep applicants updated about the progress of their 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 applicants to a Panel Physician if immediate TB investigation is required - for example, when active TB is suspected.
- for cases in Australia, applicants are to be referred to a chest clinic for active TB.
- use eMedical (where available) as per the Terms and Conditions of use.

Chief Radiologists and nominated radiologists are not:

- responsible for providing opinions or comments as to whether applicants meet the health requirement (this is the role of the MOC).
- to hand over any original completed IME paper forms or medical reports/results to applicants for submission to Department under any circumstances.
- to give their eMedical account logon and password details to any other person.
- permitted to engage in business relating to immigration services (such as a Migration Agent).

5.8 Use of locum physicians and radiologists

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

5.9 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.

5.10 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 are 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 they are 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 IMEs
- consider if their 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 members' 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 must refer the applicant to an appropriate medical professional and provide a referral letter in writing.

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 must 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, their panel membership may be ceased.*

5.11 Professional development

All Panel Members are expected to maintain currency of knowledge and undertake ongoing professional development and continuing medical education. At a minimum, this must meet their country's 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, including the Department's online training module for Panel Physicians, which is available at:

Being a Panel Member for Australian Immigration Medical Examinations - Overview | Rise 360 (articulate.com)

5.12 Disclosure of abnormal serious unrecognised medical 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 unrecognised serious medical conditions may become apparent during the examination and in such cases the Panel Member has a duty to inform the applicant of these findings.

To ensure appropriate and timely follow-up, the Panel Member must advise the applicant of any abnormal unrecognised serious medical conditions identified during the IME. Any advice provided to the applicant must be

recorded **in the 501 examination in eMedical**. Duty of care letters may be provided in some circumstances. If a duty of care letter has been provided, the letter must be uploaded to eMedical.

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).

5.13 Communication with the Department

Panel Members are required to be able to effectively communicate in English. Panel Members must ensure that all reports are completed in English or translated into English by an accredited translator. Reports must clearly show the applicant's name, date of birth, HAP ID and, if translation is required, the name, contact details and accreditation 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 clinics without eMedical may use the Panel Physician Enquiry form available on our website.

5.14 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
- advice that a full physical examination will be undertaken requiring them to undress to underwear
- the duration of the IME
- what they must bring with them (for example, their valid original passport, previous medical records and glasses or contact lenses).

The Department may ask for copies of any written information provided to applicants and this 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.*

5.15 Record keeping

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

Clinics must keep a record of the applicants they have examined, along with their HAP IDs, 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 may not be 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 must ensure correct and complete information is recorded and attached in eMedical **before** submitting the health case. This includes ensuring the correct photo, contact details, identity document information (including passport issue and expiry dates), CXR and any other reports are attached to the correct applicant in eMedical. Grading must 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 the issue.

Panel Members must observe local regulations about medical recordkeeping.

For IMEs completed on paper forms, Panel Members must keep adequate records including the applicant's details and whether an 'A' or 'B' grading was given. Comprehensive notes and evidence must also be kept for any applicants where significant abnormalities or identity concerns were identified. These records must be securely kept for a period of at least 18 months. In exceptional circumstances where a clinic does not have eMedical and are required to send paperwork to Australia, the clinic is **required to keep a copy of all completed forms, reports and paperwork sent to Australia for a period of 18 months**.

Radiology practices are encouraged to keep soft (electronic) copies of digital CXR images.
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 IME records, this must be provided. In eMedical, this is best done through the 'Print Health Case' function. Applicants may also obtain a copy of their CXR image, specialist and/or pathology reports.

5.16 Quality assurance

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.

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

- remote clinical audit of medical and radiological examinations submitted
- onsite audit visits to clinics
- virtual panel performance reviews (PPRs)
- investigation of feedback received and issues identified.

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

Remote clinical audits

The Department conducts regular quality assurance activities on IMEs completed by Panel Members. This is usually in the form of clinical and administrative audits on IMEs submitted. The purpose of these audits is to assure the quality and integrity of the IME process.

The audit framework for clinics outside of Australia is based on a three tier model that covers critical, moderate and minor error severity levels. Where issues are identified, the Department will provide constructive feedback and make all efforts to engage with Panel Members in a continuous improvement program. Errors categorised as 'critical' - that is, where there is evidence of failure to maintain integrity and quality of the examination process will result in closer monitoring of the Panel Member and possible suspension or removal from the panel. Refer to sections on *Suspension from the Panel* and *Removal from the Panel*.

Onsite audits

An onsite audit visit will generally include:

- introduction to delegated nurses and/or administrative staff involved in IME work

- a full and thorough inspection of the clinic, X-ray facilities, chest clinic and laboratory (if onsite)
- a review of information and instructions given to applicants
- a review of the training that is delivered to staff conducting, and involved in the IME process
- observation of processes including the physical examination of applicants
- discussion with the Panel Members (including case specific discussions)
- an inspection of associated offsite laboratories and chest clinics

It is expected that all 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 in consideration of departmental auditors' availability.

Onsite visits may also 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 may be provided by the Department and Panel Members must abide by these.

Panel Performance Reviews (PPR)

A PPR will generally include a scheduled live videoconference during which the following will occur:

- introduction to delegated nurses or administrative staff involved in IME work
- a virtual tour of the clinic , including associated onsite radiology facility and laboratories.
- a review of information and instructions given to applicants
- a review of TB management arrangements, including sputum collection arrangements and discussions with specialist chest physicians and treatment providers.
- discussion with the Panel Members (including case specific discussions)

It is expected that all Panel Members will participate in a PPR and the Department is notified of absence of key personnel prior to the videoconference. Individual Panel Physicians may log in to the videoconference from another location if not onsite on the day.

If the clinic provides IME service to other Migration 5 (M5) partner/s, they may also be invited to attend the PPR. This information will be provided to the clinic before the PPR.

Recommendations following PPRs may be provided by the Department and Panel Members must abide by these.

5.17 Intergovernmental collaboration

The Australian Government has close ties with its M5 intergovernmental partners, namely United Kingdom, New Zealand, Canada and the United States of America, as part of the M5 Health Working Group (M5HWG) in the area of migration health.

Panel Members must be aware that information collected by the Department about the Panel network is routinely shared with M5 partners. Applicant information is not shared. Applicants must be advised to contact the Department in relation to using their IME completed for other M5 partners for the purposes of an Australian IME.

Panel Members must be mindful that IMEs for intergovernmental partner countries may differ. If applicants 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 must exercise judgement in considering the request. Individual exam components (such as CXR) may be reused if the Panel Member is satisfied that they meet 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. All IME data must be manually entered into the relevant intergovernmental partner country's IME and graded accordingly.

5.18 The Code of Conduct for Panel Members

The M5HWG share a collective desire to support Panel Members, enabling them to work to high standards through the provision of processes that maintain and raise standard, as well as quality assurance of, and training and education to, Panel Members. This aims to ensure consistent and reliable, high-quality IME related services are performed, and extends to the behaviour of Panel Members and the level of service provided to individuals undergoing 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 M5 country. The Code of Conduct for Panel Members is accessible through the eMedical Support tab, under Support Material.

6. Applicant feedback

The Department has a client feedback policy allowing applicants, their representatives and others to provide compliments, complaints, suggestions or any information about the Department's program delivery, services or performance.

6.1 How applicants can provide feedback to the Department

Feedback may be provided by:

- **Online feedback form:** https://www.homeaffairs.gov.au/help-and-support/departmental-forms/online-forms/complaints-compliments-and-suggestions
- **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:

  https://immi.homeaffairs.gov.au/help-support/contact-us/offices-and-locations

Panel clinics and Panel Members are also encouraged to implement an individual applicant feedback process through a survey, suggestion box or other mechanism to elicit such feedback.

6.2 Managing complaints

The following is a suggested approach to resolving any complaints that may arise in relation to an IME:

- seek information regarding 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 have taken, 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.

If the applicant is still concerned, refer them to the enquiry form found on the Department's website at:

https://www.homeaffairs.gov.au/help-and-support/departmental-forms/online-forms/complaints-compliments-and-suggestions

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.

Note: *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), unnecessary tests and needing to return for more tests and/or tests that were not undertaken initially.*

6.3 What the Department does with complaints

The Department will investigate all complaints and provide the Panel Member with an opportunity to comment.

The Panel Member must respond within four business days. An extension of time may be requested, if required. Complaints received by the Department relating to clinics in Australia must be acknowledged within one business day.

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 upheld, the Department will seek the Panel Member's cooperation in addressing the issue. If the issue is determined to be significant, the Department may consider suspension or removal from the Australian Panel Network.

7. Client service

7.1 Waiting periods

Applicants must 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 business 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 business days or if they are experiencing issues managing appointments.

7.2 Incidents involving applicants

Panel Members must have clear and detailed procedures in place to deal with incidents that involve applicants or their representatives. These incidents may range from unruly behaviour, threats or violence, a medical episode during an IME, cyber-attacks and/or privacy breaches. The procedures must take into account prevailing local laws and provisions. All such incidents must be reported to the Department as soon as practicable.

7.3 Clinic facilities and hygiene

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

- obvious street sign/s to identify the clinic's entrance
- provide alcohol-based hand sanitiser in waiting room, clinical and consultation rooms
- 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 washing facilities available within the clinic premises or in very close proximity

- heating and/or air-conditioning, where appropriate
- access for applicants with restricted mobility
- routinely clean frequently touched surfaces, including clinical equipment.

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 bed and examination light
- medical equipment appropriate for an IME
- access to a properly maintained specimen refrigerator (if the pathology laboratory is offsite), which includes a log of refrigerator temperature
- handwashing 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
- a register for regular calibration and maintenance of medical equipment in accordance with relevant clinical guidelines and manufacturer instructions.

Radiology clinics

Radiology clinics must have as a minimum:

- adequate and well-maintained radiology equipment
- appropriate personal protective equipment
- radiation safety guidelines in home country
- abdominal lead shielding must be available for all applicants under the age of 55 in accordance with national radiation safety guidelines (*see 35.5 Radiology Safety)*
- facilities to protect the applicants' privacy when applicants undress, including use of an adequate curtain or screen, and gown
- change rooms
- a facility for safekeeping of applicants' possessions such as a locker.

7.4 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 CXR, blood collection and Panel Physician history and examination must be conducted without significant delay and can be expected to be completed within two hours and within one visit.

7.5 Cultural, gender and language aspects of examinations

Panel Members must be aware of cultural and gender-based preferences in relation to IME and history-taking. If the applicant does not speak the language of the Panel Member, arrangements must 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 **must not** be a family member or representing agent due to a potential conflict of interest, and to avoid risk of misinformation leading to misdiagnosis. Details of any interpreter used must be recorded in eMedical comments.*

Cases must be allocated to Panel Members with due consideration of the applicants' cultural and gender related preferences. It is for this reason panel clinics are encouraged to ensure gender balanced staff at the site. Panel clinics may use locum Panel Members of a specific gender if required.

To prevent misunderstandings, applicants must 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 D provides a diagram that clinics 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.

7.6 Chaperones

All physical examinations must be conducted in a professional manner compatible with good practice and privacy.

A chaperone, usually a clinic staff member, **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.

A parent or guardian must be present when a child is being examined, X-rayed or during blood collection.

Particular care must be taken with female and/or child 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. Similarly, when a parent or guardian accompanies a child, it is advisable to have a clinic staff member present.

The offer for a chaperone must be recorded in eMedical or on the paper forms and details of the chaperone, if present.

7.7 Children for adoption

Panel Members must be particularly careful to avoid any conflict of interest in the context of adoption cases. Panel Members must not conduct IMEs on children from orphanages with which they are associated. In the absence of alternative Panel Member options, any such associations must be declared to the Department for approval, prior to the IME.

Panel Members must take care to ensure that additional requirements are met for Subclass 102 (Adoption) visa applicants. See section 30 *Human Immunodeficiency Virus (HIV)* and section 31 *Hepatitis B and C*, for further details regarding these requirements.

Children requiring specialist assessments must not be referred to specialists associated with the orphanage in which they resided.

7.8 Setting Fees for Australian IMEs

Panel Members outside Australia are not contracted to, or paid by, the Australian Government for providing IMEs. Panel clinics may 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 Humanitarian visa applicants and Panel Members must 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 are in line with the common rates charged by local service providers for similar services. Fee structures well above or below these common rates are not acceptable and will be investigated by the Department.

Fee schedules must be transparent and must be itemised by standard examination type – for example 501, 502, 705, 707, 708, 716 and 719. An example template is below. The fee schedules must be displayed openly at the reception/waiting area of the clinic, on the clinic's website (if available) and be advised to the applicant when arranging the appointment. The fees must clearly stipulate inclusions i.e. taxes, charges, TB investigation and treatment costs. Any additional fees charged to obtain urgent processing or priority must be clearly specified.

Item	eMedical Requirement Code(s)	0-2 years	3-10 years	11-14 years	15+ years
Medical Examination	501				
Chest X-ray (CXR)	502				
Serum Creatinine and eGFR	705				
HIV	707				
Hepatitis B	708				
Hepatitis C	716				
TB screening test	719				

Fees must be all inclusive without any extra charges such as 'administration or translation fees'. Panel Members must 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 must be factored into the pricing of the 501 requirement and covered by the initial fee. There must be no extra charge for completing these examinations.

There must be no extra charge for repeat blood pressure check, even if this is not conducted on the same day.

Panel clinics are requested to provide their fee schedules to the Department when requested through regular surveys and/or email requests. Any changes made to fee schedules should be sent through to the Department for information.

Applicants must be advised of standard examination fees in advance, including any postage/courier costs for paper cases. Fees, including courier charges for paper cases, must be collected before the examination.

Applicants must 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. The Department may request copies of receipts issued for particular cases where a complaint or concern has been raised by the Department or as part of its auditing processes.

Examination fees for panel clinics located in Australia are managed through the contractual relationship between the migration medical service provider and the Department.

7.9 Costs associated with further TB testing and treatment

Financially burdening 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, 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

must be affordable. The World Health Organisation's (WHO) *End TB Strategy* aims to bring the number of persons suffering catastrophic costs for TB investigation and treatment down to zero.

The Department requires that every panel clinic has 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 must 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 CXR (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 Panel Members must ensure that the Department's requirements are still met. This includes:

TB Treatment

- clinical or case review by a 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 CXR.

Clinic accounts for managing the costs around this process must be transparent and are subject to review by the Department. This requirement does not apply to the Australian Refugee and Humanitarian caseload, as the costs for these applicants are paid by the Department.

Any other costs may 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 must 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 during specialist consultation, meet quality and integrity standards. This is a key consideration when considering the selection of these services and Panel Members must 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 (for example height, weight, blood pressure, or visual acuity measurements), the Panel Member remains responsible for the quality of the assessment, and ensuring that the correct specialist reports and documents are uploaded into eMedical.

Radiologists are accountable for the integrity of all facets of the CXR examination including uploading the correct applicant's CXR image to eMedical. Where elements are performed by a qualified radiographer, the radiologist must retain 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.

8.1 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 the relationship) must sign on behalf of any applicant 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, Panel Members may need to obtain consent from both parents and guardians. Panel Members must 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.

For applicants aged under 18 years where a guardian is signing the consent form, the relationship of the guardian to the applicant must be listed on the consent form that is signed and uploaded into eMedical. Evidence of the guardianship relationship must be provided and attached to eMedical where it is not a parent.

8.2 Digital Photo

As a part of the pre-examination stage in eMedical, clinics are required to capture a digital colour facial image 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 enabled 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 important photographs uploaded in eMedical are of biometric standard.

Use of a tripod, appropriate lighting and with the applicant seated will improve photo quality. Photos must never be "cropped" but adequate zoom at time of picture capture must be used.

More information on eMedical and reference materials can be found in the eMedical *Capturing Facial Images* tip sheet.

Note: *Photos uploaded to eMedical must 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 removal of IME operations.*

8.3 Confirming identity

Panel Members and 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. Identity questions included in eMedical or on the paper forms must be completed by the panel clinic and Identity checking must take place at all IME process points. 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. eMedical referral letters must be used where possible to ensure that identity was verified by the above mentioned service providers.

An **original passport** is the Department's primary and preferred form of identity documentation. In exceptional circumstances where the original passport is unavailable, limited alternative identity documentation is acceptable

as outlined below and in the options that are available when confirming the identity of the applicants in the eMedical system.

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) recognised/recommended document

If the IME is conducted in Australia, the following identity documents can also be accepted **in its original format (digital copies or photocopies are not acceptable)**. Further details of these arrangements are available in the *Procedural Instruction: Sch4/4005-4007: The Health Requirement*.

- an Australian birth certificate for children applying for a Temporary Protection Visa (TPV)
- an 'Alternate Evidence of Identity' letter issued by a Visa Processing Officer and sent via email to the MMSP
- an Australian issued State/Territory driver licenses or photo identification cards
- an ImmiCard

Alternative identity document in eMedical for applicants outside of Australia	When will this option be available
HAP Letter* and Certified Passport Copy**	For all cases
HAP Letter* and Photo (Stamp)***	For all cases
HAP Letter* and National ID Card	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).
National ID Card and Certified Passport Copy**	
National ID card +ID5	This option will appear for panel clinics in China only

* 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 must **not** accept identity cards unless otherwise advised by the Department in writing.*

Albania	Croatia	Italy	Oman	Slovakia
Argentina	Czech Republic	Kosovo	Pakistan	Slovenia
Austria	Egypt	Kuwait	Poland	South Korea
Bahrain	Estonia	Latvia	Portugal	Spain
Belgium	France	Lithuania	Qatar	Sweden
Bosnia	FYROM	Macau	Russia	Switzerland
Brazil	Germany	Malaysia	Romania	Taiwan
Bulgaria	Hong Kong	Malta	Singapore	Thailand
Canada	Hungary	Montenegro	Saudi Arabia	Turkey
China (where verified by ID5)	Indonesia	Netherlands	Serbia	United Arab Emirates (UAE)

If you are unsure about an identity document presented, please contact the Department. If the applicant cannot provide their passport or any approved alternative documentation, they must be advised to contact the Department. The IME cannot proceed unless they meet exceptional circumstances listed below.

Exceptions

There are two scenarios where the IME may 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

Non-migrating family members are no longer routinely required to undergo an 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. Select 'Other' in eMedical, raise an identity concern and proceed with the IME.

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 approval 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 must advise the applicant to contact their visa processing officer/centre or the local Australian overseas mission before you proceed with the IME.

Note: *You must scan and upload any documentation that is presented. Information about CXR requirements for non-migrating relatives can be found in Part C of the Instructions.*

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.

See: https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/your-health-examinations-appointment

Recording an identity concern

If there are any concerns about the person or identity documents presented, Panel Members must refer to the table below for guidance on when to raise an identity concern in the following situations. Panel Members must always complete and submit the IME in order to raise an identity concern.

Panel Members are required to **attach a scanned colour copy** of all identity documents presented to eMedical or paper forms 26/160.

Identity concern MUST be raised if there are differences between the passport and eMedical	Identity concern does not need to be raised
Name/surname do not match (that is, the names are significantly different)	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)
Gender is different in passport/reality	Gender is not recorded in eMedical (listed as unknown)
Date of birth, including where the appearance does not appear consistent with the date of birth	If the appearance has changed purely due to age or because of medical procedures or accidents.
Country of birth (for example, passport indicates	The country of birth is not listed in eMedical

Identity concern MUST be raised if there are differences between the passport and eMedical	Identity concern does not need to be raised
Lebanon and eMedical indicates USA)	There are minor discrepancies between the passport country of birth and eMedical. This includes when countries are rezoned or declared independent (for example, passport is Yugoslavia and eMedical is Serbia).
Passport number and/or other details are substantially different	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).
	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 must be uploaded to eMedical or attached to paper form 26.
	The passport number and/or issuing country are not appearing in eMedical.
Any difference in appearance of applicant with photo on the Passport, ID card or HAP	If the appearance has changed purely due to age or because of medical procedures or accidents.

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.*

8.4 Imposters and identity fraud

Panel Members must be reasonably satisfied that the applicant's face, or images of their face, match any officially recorded images of that applicant.

The Department must be notified **immediately** if:

- You reasonably suspect that the person presenting for the IME is not the applicant; for example, the person presenting does not appear to be the person in the photo(s) of the identity documents provided
- The person who is presenting for a different stage of the IME does not match the applicant's photo in eMedical; for example, the person who is presenting for the CXR 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 applicant and may be an imposter or that any fraud has been involved in the process. The person who has presented may be advised that the IME cannot proceed and they must contact the Department.

Any evidence (for example, presenting person's digital photo, a copy of the biodata page of the passport or CCTV footage) that supports your suspicion of an imposter must 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.

8.5 Specimen Integrity

It is preferable for Panel Physicians to perform blood collection onsite. Sputum collection must occur onsite or at an accredited 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 must include:

- 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)
- accurate specimen identification (using non-removable labels) must include the HAP ID and one other identifier such as the applicant's name or date of birth.
- labels must 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 (where available) or transportation to the laboratory within one hour
- where refrigeration is not available and specimen is kept at room temperature, secure storage away from direct sunlight, heat sources and humidity
- 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 B of the Instructions.

Pathology reports must be in English and include, at a minimum, the following biodata:

- the date the test was performed (using Gregorian calendar)
- applicant's full name in English
- applicants date of birth

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 identifies limited further circumstances where specialist reports must 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

must 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 applicants why further investigation is needed. Panel Members must 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 must also be offered a copy. Specialist referral letters must be generated via eMedical. The specialists must complete the relevant identity verification part of the referral letter and return it to Panel Member with their report. The Panel Physician must provide a clear written instruction to the Specialist on the investigations required, the timeframe of the follow up test and a comprehensive report. Panel Members must 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 required. Substandard reports will not be accepted. It is preferred that specialist reports are typed, not hand-written. Panel Members must only refer applicants to specialists in whom they have confidence regarding their clinical skills and reporting.

In general, Panel Members must ensure that 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 a language other than English must be translated.

If the requested specialist is not available in-country, the Panel Physician, or any other suitable specialist, must 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 must be made on the applicant's case noting there is no requested 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 must be explained in depth the possible timeframe for TB screening, results and treatment. Panel Members must 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.

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

10.1 Submitting 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 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 business days of the examination**, unless additional examinations and/or tests 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 must regularly review their eMedical inbox. If any applicants decline to return or complete the requested examinations, the case must 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 where they are eMedical enabled.

10.2 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**

See: https://immi.homeaffairs.gov.au/help-support/departmental-forms/pdf-forms

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

Panel Members must 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.

Department of Home Affairs
Attention: Mailroom
Immigration Health
Level 3, 101 George Street
PARRAMATTA NSW 2150 AUSTRALIA

Important: The envelope must be prominently marked 'CONFIDENTIAL – MEDICAL RECORDS'.

For more information on where to send completed paper forms, refer to '*Where to send visas Australian Immigration medical forms, results and x-rays'* on the Department's website.

See: https://immi.homeaffairs.gov.au/help-support/tools/panel-physician-gateway/conducting-australian-visa-medicals.

Panel radiologists must send the completed CXR examination paper Form 160 and related films directly to the examining Panel Physician so that they can complete the IME and forward the completed records to the Department.

Documents and reports must not be stapled to the CXR films. Chemically developed films must 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 may 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 may 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 and on the website (if applicable). A fee must 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 IME records and reports must not be provided to family members, migration agents, or anyone else, without the written permission of the applicant, and ensuring that the written consent was actually provided by the applicant. If an applicant has any queries in relation to the health requirements, Panel Members must refer the applicant to his/her visa processing officer/centre.

In the exceptional circumstances where a clinic does not have eMedical and are required to send paperwork to Australia by mail, the clinic is **required to keep a copy of all completed forms, reports and paperwork sent by mail to Australia for a period of 18 months.**

10.3 Incomplete Immigration Medical Examinations

IMEs that have already commenced must 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
- refuses to do an examination as per The Health Requirement (for example: LTBI screening 719 examination, or BBV serology screening for HCW)
- 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.
- document the details why the examinations are required and the reasons the applicant refuses to undertake the tests/examinations

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.

10.4 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. The use of any other version 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

11.1 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 must, however be strongly encouraged to consider immunising their children against Hepatitis B, diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, haemophilus influenza 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 must counsel parents accordingly and advise them to complete outstanding immunisations before they travel to Australia. Panel Physicians must 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 vaccination is strongly recommended for women of child-bearing age; however, it is contraindicated if they are already pregnant.

Live vaccines are generally contraindicated for most people who are severely immunocompromised and must not be administered in these cases, unless consultation with a specialist has occurred.

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

See: Immunisation | Australian Government Department of Health and Aged Care

See: What are immunisation requirements - Services Australia

Recording of vaccinations (951)

All vaccinations, including vaccines administered by the panel clinic or evidence provided by the applicant of vaccines administered elsewhere, must be recorded under the 951 Vaccinations exam, with the appropriate vaccination selected from the drop down options. See the 951 Vaccinations exam tip sheet available via eMedical under Medical Support > Australia Specific > Tip Sheet: Recording 951 Vaccinations

COVID-19 vaccination

Panel Physicians must seek applicants' consent to record COVID-19 related health information, when applicable, noting that the need for applicants to provide COVID-19 related health information is not mandatory. This includes recording that an applicant consents to receiving a COVID-19 vaccine administered by the panel clinic (where authorised) or evidence of any previous COVID-19 vaccination they may have received elsewhere.

If an applicant has not received a COVID-19 vaccination or there is insufficient information available, Panel Physicians must not manually add the 951 Vaccinations examination to the health case unless:

- The Panel Physician has sighted reliable proof of evidence of a COVID-19 vaccination certificate (i.e. a vaccination certificate has been presented) for vaccines provided elsewhere. Note that for recording purposes, if the COVID-19 vaccination was administered elsewhere, the vaccination information can be

recorded in eMedical, regardless of whether the vaccination is **approved** or **recognised** by Australia's Therapeutic Goods Administration (TGA)

- The Panel Physician is authorised to administer a COVID-19 vaccine and it was provided at the time of the IME.

11.2 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 in implementing specific measures to assist in managing risk. The Department will, 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:

https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/threats-to-public-health

11.3 DNA testing

The Department may ask Panel Physicians to undertake DNA sample collection in liaison with a nominated DNA testing laboratory in Australia. Clinics will be advised of specific requirements by the visa processing office when this is required. This is not part of the IME but a separate requirement for visa or citizenship 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 must be provided to the applicant by the Panel Member collecting the sample.

The Panel Member must 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 cases
- counselling options for applicants if the results show unexpected biological results.

Consent

The Panel Member must obtain written consent from the applicant for DNA testing to be performed.

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 must 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.*

11.4 The Departure Health Check (DHC)

The Department offers a DHC to Refugee and Special Humanitarian Program (RSHP) visa holders prior to their entry into Australia.

The DHC is generally conducted within 72 hours of the visa holder's confirmed departure for Australia. Visa holders identified at the IME as having significant health needs, including those who may require a Medical

Escort, can commence the DHC up to four weeks before date of departure. If it is identified during the IME that a DHC should be done early due to significant health needs or the need for an escort, ensure that the need for an early DHC is clearly noted in the IME notes.

During the IME, long standing or chronic health conditions should be identified and noted on both the Medical Examination (501) and/or the Resettlement Needs Examination (948) in eMedical. This information will be reviewed and updated during the DHC.

The purpose of the DHC is to:

- Identify and document details of any new medical conditions that have developed or existing medical conditions that have improved or deteriorated since the IME and upload relevant specialist reports to eMedical
- Ensure that any previously identified medical conditions are being well managed and that the visa holder's condition has been optimised for travel
- Ensure that visa holders are fit to travel by air and to identify any specific health needs which may need management or support during travel, including ascertaining whether a medical escort is required
- Ensure that visa holders have not developed any communicable diseases, such as TB, since undertaking their IME, which might affect their ability to travel safely
- Review immunisation status and provide vaccinations and parasite/infestation treatment as required
- Manage specific health needs depending on country of origin (e.g. malaria screening)
- Support facilitation of arrangements for medical care and settlement needs on arrival in Australia
- Facilitate resettlement and protect the health of the Australian community by mitigating acute health issues before arrival to Australia

If significant medical abnormalities or health concerns are identified, the Panel Member should review and manage these to ensure the visa holder is fit to travel.

Panel physicians should be mindful of cultural and other sensitivities when undertaking the DHC and advising of any results

Further information and supporting material relating to Departure Health Checks is available at: departure-health-check-supporting-material.pdf (homeaffairs.gov.au).

11.5 Public Health Risk Screening

Permanent visa holders who were granted a visa outside of Australia may be required to enter Australia before a first entry date (FED), which may be based on the expiry date of the visa holder's health clearance.

If the visa holder has not entered Australia prior to their FED and the health clearance has expired, some visa holders may be requested to undergo additional medical examinations to screen for public health risks, specifically TB.

In these circumstances, Panel Members may be requested to conduct a 'public health risk' screening. This screening functionality is conducted using eMedical.

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 where the clinic is not eMedical 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

As an applicant may attempt to conceal health conditions, it is **important** Panel Physicians ask the applicant at the time of the IME the health declaration questions in order to be satisfied that the applicant understands the questions and confirms the answers. A third party may have completed the health declaration and/or medical history on behalf of the applicant, which is why it is essential that the applicant is directly asked the questions again during the IME. The Panel Physician must take note of any discrepancies or abnormalities as the applicant's health 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 must also ask other relevant 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 must 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 wellbeing.

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 (including carers) 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 medications. If significant conditions are identified, these must be recorded.

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

Previous medical records and/or specialist reports that are available to the Panel Physicians at the time of the IMEs must be reviewed and attached to the 501 examination if relevant.

12.1 Refugee and humanitarian visa applicants

For refugee and humanitarian visa applicants, a review and documentation of current long-term and regular medication must occur during the IME. Panel Members must record any medication that the applicant is likely to require during travel and post arrival, noting that an IME may occur many months prior to travel.

13. Physical Examination

Applicants are required to be undressed to underwear for examination as per Appendix D (females must keep brassiere on). All applicants must be offered a chaperone. 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 must incorporate cardiovascular, respiratory, gastrointestinal, endocrine, neurological, musculoskeletal and haematological (including skin, head and neck, chest, abdomen, back and extremities), and a mental health assessment.

The examination must pay particular attention to respiratory findings and 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, supraclavicular and axillary nodes in all applicants.

Specifically, palpation of lymph nodes, with a specific emphasis on the cervical chain, supraclavicular and axillary nodes, must be undertaken and documented.

It is also important to exclude signs of extrapulmonary 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 must be determined accurately and recorded in centimetres and kilograms respectively. eMedical automatically generates a BMI score.

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

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

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 must be undertaken with corrective lenses if they are usually worn, using a Snellen or similar test, with the applicant standing at the appropriately marked distance from the chart. The results must be recorded in metric fractions. For illiterate applicants and children, E charts or picture charts must be used.

If defective vision is found, record the cause in the 501 exam (if known), for example: myopia, hyperopia or astigmatism. If an applicant has not brought glasses, pinhole testing for acuity must be used and this must 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.

Refer to Appendix E (Guidelines for Specific Medical Conditions) for required investigations and grading of visual impairment. If the visual impairment affects the applicant's functionality, this should be documented and 903 examination to assess the ADLs must be performed.

Note: *eMedical will automatically grade as 'B' if corrected visual acuity is less than or equal to 6/24 in the better eye.*

16. Serum creatinine and estimated glomerular filtration rate

A serum creatinine blood test and estimated glomerular filtration rate (eGFR) calculation is required for any visa applicant 15 years and older who is required to undertake an IME.

Applicants under 15 years old who are at risk of chronic kidney disease will also be required to undertake a serum creatinine blood test and eGFR.

Testing requirements for chronic kidney disease (705 Serum Creatinine and eGFR) will be automatically generated in eMedical for applicants 15 years or over.

Panel Physicians are required to manually add the 705 Serum Creatinine and eGFR exam for applicants under the age of 15 years where there is an identified risk of chronic kidney disease (refer to section below 'Risk factors for chronic disease in children'.

For applicants under the age of 15 years, if no risk factors for chronic kidney disease are identified, the Panel Physician must record these clinical considerations within the 501 medical exam "*Records Results – Doctor's Comments*" free text field (example comment: *no risk factors for chronic kidney disease were identified*).

If not routinely provided by the laboratory, eGFR must be calculated by the Panel Physician and recorded in eMedical via the 705 exam. Clinics **must use** the sample tools listed below to calculate eGFR.

Note: *Do not use the MDRD (Modification of Diet in Renal Disease) equation, as it tends to underestimate the GFR levels.*

Applicants 18 years and older: https://kidney.org.au/health-professionals/egfr-calculator or a tool using the CKD-EPI equation (Chronic Kidney Disease Epidemiology Collaboration).

Applicants under the age of 18: https://www.kidney.org/professionals/kdoqi/gfr_calculatorPed or a tool using the CKD-EPI equation (Chronic Kidney Disease Epidemiology Collaboration).

Note: *Cystatin C and blood urea nitrogen (BUN) are not necessary for the calculation.*

Pregnant applicants: eGFR is not valid for use in pregnancy. A serum creatinine test must be completed and the results attached to the eGFR examination. Panel Physicians must not record or reference the serum creatinine

and instead record 999 in the eGFR results field, and include a note recording pregnancy as the reason within the 705 General supporting comments. For details on grading, refer to eGFR Calculation and grading below.

16.1 eGFR results and grading

An eGFR under 60ml/min may indicate decreased kidney function. eMedical will auto-B grade the 501 examination where the eGFR is less than 60ml/min. These cases will be referred to a MOC for review.

The eGFR must always be calculated using the attached calculator tool, if not routinely provided by the pathology lab. If the laboratory has reported the eGFR>90, then the value 90 can be entered in the "eGFR Record Result section" in eMedical. The pathology result with serum Creatinine should be uploaded into eMedical under 705 examination section.

For pregnant applicants, Panel Physicians must B grade the case if the serum creatinine is >1.02 mg/dL (90 µmol/L), as eMedical will not auto grade pregnant applicants. Panel Physicians must consider, in conjunction with the creatinine results, the detailed history and ensure that there are no other signs of kidney disease (such as ankle oedema, hypertension). Such information can be attached to the 705 eGFR section. Pregnant applicants with a serum creatinine <1.02mg/dL and no signs of kidney disease can be A graded.

In some instances, a MOC will require and request a Nephrologist report (via 115 deferral).

Estimated Glomerular Filtration Rate result (eGFR in mL/min/1.73m^2) reading can only be recorded between 10 and 999 in eMedical. For an eGFR result of less than 10, record 10 (being the lowest number able to be recorded in eMedical) with a note against the test stating the actual eGFR reading. Refer to tip sheet ‘Recording 705 Serum Creatinine and Estimated Glomerular Filtration Rate (eGFR) for further information.

16.2 Risk factors for chronic kidney disease in children

As stated above, Panel Physicians are required to add a 705 exam for children under the age of 15, only where a clinical risk of chronic kidney disease has been identified.

Risk factors include:

- Chronic disease, such as diabetes, hypertension, cardiovascular disease, obesity
- Congenital and genetic anomalies of the kidney and urinary tract, including dysplasia, reflux nephropathy, polycystic kidney disease, obstructive anomalies, Alport syndrome, cystinosis
- Glomerular disease, including focal segmental glomerulosclerosis, glomerular nephritis
- History of acute kidney injury, such as pyelonephritis, recurrent UTIs, haemolytic uraemic syndrome, previous malignancy
- Family history of chronic kidney disease
- Prematurity
- Other identified risk factors for chronic kidney disease.

Note: Panel Physicians should use their clinical judgement as to whether the 705 examination be added for children under 15. A singular risk factor may not indicate a 705 exam is required. The adding of the 705 must be assessed on a case-by-case basis.

17. Cardiovascular Disease

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

17.1 Hypertension

If the initial BP is high (systolic >140 mmHg and/or diastolic >90mmHg), a repeat measurement will be automatically generated in eMedical and it must be repeated. Further repeat blood pressures, to a maximum of three (3) in total, may be done at the Panel Physician's discretion. If these remain elevated and hypertension is detected, further follow up and/or investigation is needed (via referral to a cardiologist or Family Physician) where:

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

In cases where the repeat BP is >160mmHg systolic and/or >100mmHg diastolic, the 501 exam will automatically be 'B' graded in eMedical. Where the repeat BP is >140 mmHg systolic and/or >90 mmHg diastolic, inform the applicant of the reading and refer them to their treating physician for follow up. For further information refer to 5.12 Disclosure of abnormal health conditions to applicants (Duty of Care) section for further information.

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

These cases must be 'B' graded.

17.2 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 must be 'B' graded.

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

Appendix E 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 must not be asked to remove their brasserie for this examination.

18.1 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 CXR 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, including 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 by a MOC and further specialist referrals requested where required.

19. Nervous system (including sequelae of stroke or cerebral palsy)

Panel Physicians must 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 must be performed. All neurological abnormalities must 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, geriatrician, paediatrician, occupational therapist, occupational health physician or orthopaedic surgeon.

An ADL (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. ADL assessment is provided in Appendix G for non eMedical cases.

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 ADLs, 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 spectrum disorder (paediatric review may be more appropriate)
- chronic alcohol abuse
- drug dependence or substance abuse
- eating disorders
- chronic mental health conditions (for example, chronic anxiety, depression or adjustment disorder, obsessive-compulsive disorder, phobias and suicidality)
- mental health conditions that have required hospitalisation or that cause ongoing functional impairment
- mental health conditions or related symptoms that are poorly controlled on psychotropic medications or that have only partially responded to the same.

20.1 Dementia

If abnormal mental or cognitive state is suspected, Mini Mental State Examination (MMSE) and 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 G for non eMedical cases.

The MMSE is one of many screening tools that can be used to assess cognitive decline. The MMSE tool is available in eMedical (examination 901) and may be added as necessary. The tool must be adapted as appropriate, both linguistically and culturally. The test questions must be performed in the applicant's own language or with the assistance of an interpreter. If the applicant has speech problems, a language barrier to assessment or low level of literacy/education are present, this must be recorded. eMedical will generally automatically 'B' grade the case. These cases must be 'B' graded if manual grading occurs.

If Panel Physicians suspect cognitive decline, a psychiatrist's or geriatrician's opinion is to be requested.

20.2 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 speech development and major milestones, is part of a general physical examination and must always be undertaken in children aged five years and under.

Panel Physicians must avoid relying solely on parents/guardians as interpreters when conducting developmental assessments of children as this may not result in an impartial assessment.

Note: *For children who have been deprived of adequate stimuli, such as those who have been institutionalised, 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 F provides additional guidelines for those submitting paper cases. Paediatric referral (examination 124) may be considered.

If developmental milestones are abnormal, a paediatrician's report must be obtained and attached (Paediatric Report – examination 124). An occupational therapist or developmental psychologist report may also be useful. If the child is known to have a developmental delay, then a report from their own paediatrician may be valuable, along with school reports for older children.

Note: *Please refer to Appendix F 'Chart of Early Child Development milestones'.*

22. Gastrointestinal system

Examination of the gastrointestinal system must include, but not be limited to, examination of the abdomen and detection of abnormalities (jaundice, hepatomegaly, tattoos and evidence intravenous drug use). Investigation may be required and may include ultrasound scan, hepatitis serology testing, and/or a recent gastroenterologist or specialist report, if any abnormalities are identified or any significant history disclosed.

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

History of and operative scars from commonly performed surgery, such as appendicectomy, 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 must include but is not limited to gait, power and general mobility and functionality. Where indicated, a detailed examination must 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 ADLs and live independently.

The ADL (examination 903 or Appendix G) is required if there are musculoskeletal conditions that interfere with ADLs. Details of prescription medication must be recorded.

24. Skin and lymph nodes

The presence of operative scars must be correlated with the applicant's history. It is **not** necessary to record scars associated with common 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 and axillary lymph nodes must be palpated. Enlargement of lymph nodes must 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 must be considered as part of the differential diagnosis and explored.

Examination of the external genitalia must not be done for applicants of any gender.

For female applicants, gynaecological examination (vaginal) or pelvic examination is **never indicated** for the purpose of an IME. If there is a clinical suspicion of gynaecological malignancy, refer the applicant to a gynaecologist. For male applicants with a clinical suspicion of reproductive or genital malignancies, refer to the appropriate specialist.

25. Evidence of drug-taking

Details must 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 must 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 must be added manually and, if positive, the case must be 'B' graded.

26. Breast examination

Breast examination is **not routinely required as part of the IME** and must only be conducted if a breast related condition is declared by the applicant and it is deemed appropriate to examine.

If breast examination is clinically indicated, applicants must be asked to remove brassieres for the purpose of breast examination only. Consent for breast examination must be obtained and documented. Examinations must be conducted with sensitivity and, in the case of a male Panel Physician, in the presence of a chaperone (chaperone's details must be documented, refer to section 7). If the applicant is unduly anxious or upset about a breast examination, do not insist. Instead, note that a breast related condition was declared, and that the applicant declined examination.

If a breast lump not previously investigated is identified, or there is any other suspicion of malignant disease the Panel member has a duty to inform the applicant and/or their treating doctor. The Panel member may provide the applicant with a Duty of Care letter for follow up and investigation by a physician/medical officer and/or specialist review, so that further investigations such as mammography, ultrasound scan and/or biopsy may be arranged. Refer to *5.12 Disclosure of abnormal health conditions to applicants (Duty of Care)* section for further information.

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 (from not more than 12 months ago) specialist report is required. Benign breast lesions such as fibro adenoma or fibrocystic disease do not need to be recorded in eMedical and may be 'A' graded.

27. Endocrine system

Applicants who are known to have diabetes mellitus, must be graded as per Appendix E. If there is no evidence of end-organ complications, no further investigation is needed. However, if complications are known or suspected, the applicant should see their own doctor for a medical opinion and/or treatment.

Signs of end-organ disease include:

- chronic kidney disease
- reduced visual acuity or retinopathy
- history or signs suggestive of coronary artery disease
- signs of peripheral artery disease including weak peripheral pulses, vascular bruits, foot ulcers
- history or signs of peripheral neuropathy

- history of stroke/ TIA or focal neurological signs
- T2DM with an insulin requirement (indicative of pancreatic failure).

Examination of the endocrine system must include thyroid examination. Applicants known to have benign thyroid disease do not need additional investigations such as thyroid function tests and must 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 must provide comment if an applicant has any significant abnormalities, 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 their hearing may be considered satisfactory. If there is a hearing impairment, the communication skills that are used by the applicant must be recorded. That is, it must 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, impact on ADLs or ability for employment 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 G) needs to be completed for any applicants where there is concern about their ability to carry out ADLs, 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. HIV testing must also be added when specified conditions, or circumstances have been identified, such as where a person is diagnosed with active tuberculosis.

A summary is provided in the following table.

Type of Applicant	Test for HIV	e-Medical
Permanent and provisional visa applicants aged 15 years or older	Yes	Auto
Non-migrating relatives of permanent and some provisional visa applicants, aged 15 years or older, if requested by the visa officer to undertake medicals	Yes	Auto
Children who have been, or are to be, adopted by Australian citizens or permanent residents	Yes	Add if not auto generated
Unaccompanied humanitarian minors	Yes	Add

Type of Applicant	Test for HIV	e-Medical
Children under 15 years of age with clinical suspicion for HIV infection, or have a history of blood transfusions or haemophilia, or if the mother is HIV-seropositive.	Yes	Add
Temporary Entry Applicants with clinical signs of AIDS	Yes	Add if not auto generated
All applicants who intend to work as, or study to be a physician, nurse, paramedic or dentist*	Yes	Add if not auto generated
Persons known or found to be infected with Hepatitis C or HIV	Yes	Auto
Persons where there is evidence of previous or current intravenous drug use	Yes	Add
Persons where active TB is diagnosed	Yes	Add

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

Venepuncture must be done onsite at the panel clinic once the applicant's identity has been confirmed, unless the clinic is specifically authorised by the Department to utilise an offsite pathology laboratory.

The identity of applicants must be confirmed to prevent substitution.

30.1 Pre-test counselling

Before a HIV test is performed, pre-test counselling must be provided to the applicant by the Panel Physician.

The Panel Physician must, 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.

30.2 Acceptable screening tests for HIV

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

First-line HIV screening must 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 must 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.

30.3 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 must be performed with a confirmatory immunoblot assay. If these are not available, retesting with two alternative kits is advised.

30.4 Positive results and post-test counselling for HIV

If an applicant is found to be HIV-positive, based on reactive initial and/or confirmatory tests and is not already known to be infected, the Panel Physician must inform the applicant and/or their treating physician and provide **post-test counselling in accordance with local protocols and standards.**

The following points must 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.

The panel physician must ensure the applicant has arrangements to follow up the positive result with their treating doctor. Refer to section 5.12 Disclosure of abnormal health conditions to applicants (Duty of Care) for further information.

If an applicant is outside Australia, a positive 707 exam result will generate a requirement for an HIV Specialist Report (eMedical code 722). CD4 and viral load must be included in the specialist report.

If an applicant is in Australia with a known HIV positive status and already on HIV treatment, Panel Physicians must upload any treating doctor reports and any pathology results that the visa applicants bring with them at the time of IME. If these documents are not available at the time of the IME, Panel Physicians are required to document the any of the following details, if known by the applicant, in the Medical History section of the 501 examination including:

- year of diagnosis
- country of diagnosis
- antiretroviral therapy details, including:
  - date commenced
  - compliance with treatment
  - where the medication is sourced
- the sexual health clinic, GP or specialist in Australia managing their HIV, including:
  - last pathology blood test, and any known results from latest viral load and/or CD4 count
  - last visit and/or next scheduled visit.

All applicants with known HIV must 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 Australian health requirement, the Panel Member must state that this is a matter for the Department to consider. Any further enquiries by applicants about the Australian health requirements must be referred to the 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.

Type of applicant	Hepatitis B Surface Antigen Test (708)	Hepatitis C Antibody Test (716)
Applicant who is pregnant and intending to give birth in Australia	Yes	No

Type of applicant	Hepatitis B Surface Antigen Test (708)	Hepatitis C Antibody Test (716)
All provisional and permanent visa applicants aged 15 years or older born in high Hepatitis B risk countries	Yes	No
Children for adoption Children under 15 years of age born in high Hepatitis B risk countries who have been, or are to be, adopted by Australian citizens or permanent residents on a Subclass 102 (Adoption) visa.	Yes	No
High risk applicants o Permanent applicants with a declared history of Hepatitis B or Hepatitis C or blood transfusions o applicants showing clinical symptoms and signs of Hepatitis B, Hepatitis C infection or liver disease o applicants where there is evidence of previous or current intravenous drug use o applicants with clinical indicators or history giving rise to a possibility of infection (for example, biological mother positive)*	Yes	Yes
All visa applicants intending to work as or study to be a physician, nurse, paramedic or dentist	Yes	Yes
Persons known or found to be infected with HIV	No	Yes
History of an abnormal or reactive Hepatitis B or Hepatitis C blood test	Yes	Yes
Offshore refugee and humanitarian visa applicants (Subclass 200 series) aged 15 years and over	Yes	Yes
Onshore refugee and humanitarian visa applicants aged 15 years and over: Subclass 449 (Humanitarian Stay Temporary) visa Subclass 786 (Temporary (Humanitarian Concern) visa Subclass 851 (Resolution of Status) visa Subclass 866 (Onshore protection) visa Subclass 785 (Temporary Protection) visa Subclass 790 (Safe Haven Enterprise) visa	Yes	Yes

For the list of low Hepatitis B risk countries, see '*Countries with low risk of Hepatitis B*' at: https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/what-health-examinations-you-need

Clinical evidence of Hepatitis B or C infection includes symptoms, signs or test results indicating liver disease, cirrhosis or hepatocellular carcinoma (jaundice, scleral icterus, abdominal pain, ascites, urine changes, hepatosplenomegaly, palmar erythema, bruising etc).

Allied health workers such as occupational therapists, physiotherapists, speech pathologists 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 and liver function test are required. In the case of declared/known hepatitis C or a newly diagnosed positive Hepatitis C Ab test, in addition to the liver function test, a Hepatitis C RNA test and HIV test are required to be performed at the same time.

Ultrasound scans and gastroenterologist reports are needed only if liver function is abnormal. Reports must include serological markers, Hepatitis B DNA or Hepatitis C RNA and comment regarding management options, including any recommendations for drug treatment.

All family members of those with Hepatitis B infection must 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 must be 'A' graded.

31.1 Positive results and post-test counselling for Hepatitis B and C

If an applicant is found to have positive results for any unknown or undeclared blood borne viruses, the Panel Physician must inform the applicant and/or their treating physician and offer post-test counselling in accordance with local protocols and standards. For example, this may include advice on preventing transmission and vaccination for close contacts of those testing positive to hepatitis B antigen. The Panel Physician may provide the applicant and/or treating physician with a Duty of Care letter for follow up counselling and management with their own physician or a suitable specialist. Refer to section *5.12 Disclosure of abnormal health conditions to applicants (Duty of Care)* for further information.

32. Venereal Diseases' Reference Laboratory (VDRL) test

Syphilis screening (examination 712) is required for refugee and humanitarian (Subclass 200 series) visa applicants aged 15 years and older.

The Department recommends Panel Physicians follow the traditional syphilis screening algorithm using a non-treponemal serological test such as a Venereal Disease Research Laboratory (VDRL), Rapid Plasma Reagin (RPR), Toluidine Red Unheated Serum Test (TRUST) or equivalent test for syphilis.

If the initial non-treponemal screening test is positive or reactive, confirmatory testing on the same blood sample must be performed using a treponemal test. Treponemal tests include CMIA (Chemiluminescent microparticle immunoassay); EIA (Enzyme immunoassay); TPPA (Treponema pallidum Particle Agglutination Assay); TPHA (Treponema pallidum Hemaglutination Assay); and FTA-ABS (Fluorescent treponemal antibody absorbed) tests.

If the result of the confirmatory test is also positive, treatment should be provided by a suitable doctor (i.e. ideally with experience in syphilis management for staging and appropriate treatment). This should be noted on the IME, as part of the 712 Syphilis examination. Unless treatment has failed or follow up is needed in Australia, the case can be graded 'A'. Syphilis should be reviewed at the Departure Health Check (DHC). For details, refer to the Departure Health Check supporting material: departure-health-check-supporting-material.pdf (homeaffairs.gov.au)

Please also refer to Australian guidelines for further information on syphilis https://sti.guidelines.org.au/sexually-transmissible-infections/syphilis/

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 must ensure that they have reviewed the CXR 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 must be discussed with the Panel Radiologist. The 501 grading that the Panel Physician decides must reflect the 502 examination. **If the 502 Chest x-ray is B graded then 501 must be ‘B’ graded.**

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

33.1 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’. A ‘B’ grade does not necessarily mean that the applicant will not meet the health requirement; however, the case will be reviewed by a MOC.

33.2 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, minor medical conditions and previous illnesses with no ongoing implications are not significant. Appendix E provides more guidelines for grading specific medical conditions.

Any condition which does not impact functional capacity or long-term prognosis may be ‘A’ graded. Relevant fields in the eMedical 501 or 502 examination must be marked normal, and the case ‘A’ graded. Brief details on the

condition must be added as general supporting comments next to the ‘A’ grading. Such conditions include, but are not limited to:

Examples of Insignificant Medical Findings	
Allergic rhinitis Asthma (mild and well controlled) Astigmatism (corrected) Breast fibroadenoma Benign cysts (for example in breast, ovaries, kidney or liver) Dental disease Gastroesophageal reflux disease or indigestion Haemorrhoids Hernias Hypercholesterolemia Hyperlipidaemia Hypo/Hyperthyroidism (uncomplicated)	Infertility Menopause Minor musculoskeletal injuries/ conditions Minor skin conditions (for example, acne, dermatitis, keloids, lipoma, vitiligo) Minor Surgery: Appendicectomy, Caesarean section, cholecystectomy, cosmetic surgery, nasal operations or corrections, rhinoplasty, tonsillectomy, varicose vein stripping Minor visual conditions (i.e. myopia, corrected astigmatism) Prostatic hypertrophy (benign) Tattoos Uterine fibroids

Examples of Insignificant CXR Findings	
Aortic calcification Apical capping or thickening (<1cm with smooth border) Atelectasis Azygous fissure/lobe or other accessory fissures Bony island Breast implants Cardiomegaly, mild (CTR < 60%) Dextrocardia Minimal costophrenic angle blunting	Nipple shadows Pectus excavatum Raised hemi-diaphragm Rib abnormalities (for example cervical ribs, previous rib fractures, bifid ribs, congenital rib fusion) Scoliosis Single fibrotic streak/band/scar and rest of lung fields normal Single solitary calcified nodule (<1cm)

Note: *These lists are not exhaustive.*

33.3 ‘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, 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 ADLs without family or other assistance, and nursing or institutional care is not needed now or in the foreseeable future
- Normal CXR (where indicated).

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

33.4 ‘B’ Grades

‘B’ grades must 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 must ensure to provide sufficient notes on reasons for ‘B’ grading the case.

A ‘B’ grading 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 E. For details of situations where eMedical automatically grades ‘B’, see Appendix E. Although it is not possible to override the automatic ‘B’ grade in eMedical, the Panel Physician must use their clinical judgement and if they disagree, they must 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 the 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 non-eMedical enabled clinics using paper forms, the applicant **must** return to the panel clinic where the original IME was conducted. For eMedical cases, the applicant is advised that it is preferable that they 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 occurs where the applicant has relocated.

34.1 Health undertakings

A health undertaking is an agreement that an applicant makes with the Australian Government to attend a health clinic in Australia for follow-up care on a condition for which the health undertaking was requested. Only a MOC can determine whether a visa applicant requires a health undertaking.

A health undertaking is required for applicants whose health examination indicated exposure to TB or other health conditions of concern such as Hepatitis B, Hepatitis C, HIV or Leprosy.

Further general information regarding health undertakings is available on the Department of Home Affairs website: https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/health-undertaking.

Part C: Completing an immigration CXR examination

This part of the Instructions provides advice for Panel Radiologists and Radiographers on how to complete an immigration chest radiography 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 must be attached to the completed paper form 160.

All CXRs must 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 CXR

35.1 CXR 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 must be provided, for example, left lateral image. Larger file sizes of 4-5 Mb are acceptable (the relevant box must be checked in eMedical).

35.2 Film size for paper cases

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

35.3 Radiographic technique

- all adult CXRs must 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 must be taken in full inspiration – this lowers the diaphragm to the level of the 10th or 11th rib posteriorly
- the position of the applicant must 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
- it is desirable for scapulae to 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 must be just visible through the heart shadow
- the CXR beam must be centred at T5 or T6 vertebral body
- the distance of the CXR tube to the film must be 180 cm (six feet)
- all CXRs must include costophrenic angles
- apices must 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.

If a radiologist identifies that a CXR image has an artefact, the case must be graded ‘B’ and a MOC can determine whether a repeat CXR image is required or whether an assessment can be made despite the artefact being present.

35.4 Additional views

An apical lordotic view must 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 CXR must be taken with nipple markers to confirm. The extent and likely activity of any disease present must be described and any necessary further investigations recommended. Panel Radiologists must record all abnormalities in the 502 examination comments field.

Computerised Tomography (CT) scans must 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.

35.5 Radiation safety

Radiation safety must be maximised by:

- Lead shielding should be used in accordance with the national radiation safety standards. The medical imaging practitioners must comply with the radiation safety legislation and its application in daily practice such that the overall radiation dose is not increased. The medical imaging practitioners are responsible for the safe and accurate delivery of the diagnostic dose of radiation to the clients.
- lead shielding should be available for all applicants, including male and female applicants aged 55 years and under and pregnant women who have a confirmed gestational age of at least 14 weeks and choose to proceed with the CXR
- lead shields should be stored appropriately - not folded as this may crack the lead and allow radiation leakage
- the integrity of lead shields should be tested 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 or an illuminated radiation warning sign at the time of exposure
- displaying a visible radiation hazard warning sign.

35.6 CXR image identification

The CXR image must indicate:

- the date of the examination (using the Gregorian calendar)
- applicant's full name **in English**
- applicant's date of birth
- name of the X-ray clinic in English
- anatomical side markers.

eMedical enabled clinics must also ensure that the file name for uploaded CXR images in eMedical is as per agreed naming conventions in *Module 8 of the eMedical User Guide,* found in the eMedical Support tab.

35.7 Female applicants

Female applicants of reproductive age may be unknowingly pregnant at the time of the CXR 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 must 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 must 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 submit the case.

Applicants from higher TB risk countries who are more than 14 weeks pregnant must be advised that they have the option of either:

1. deferring the CXR until after giving birth meaning their IME and visa application cannot be finalised until this CXR examination is completed, or
2. proceeding with the CXR, with appropriate advice and precautions given to the applicants (Please refer to *35.5 Radiation Safety* Section).

X-rays must not be undertaken if less than 14 weeks pregnant.

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:

- The applicant must complete the consent form.
- The field size must be strictly limited to include the chest area only. The field is not to include the abdomen or head.
- Double lead wrap around abdominal and pelvic shielding **must** be used.

- The radiology clinic must confirm on the paper 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: https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/what-health-examinations-youneed

35.8 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*", 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 must be made on the paper Form 26 to the presence or absence of any history or clinical evidence of TB. The case must be graded 'B'.

35.9 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 must 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 CXR 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 CXR image and the radiologist's report prior to submitting the case to ensure accuracy of reporting and to address any abnormalities. Panel Physicians may ideally have access to specialised reporting equipment, but this is not mandatory.

The radiologist must pay particular attention to the so-called 'hidden' areas:

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

36.1 Reporting TB findings

Radiologists must take particular concern when reporting findings which could be consistent with TB disease.

Findings which may be consistent with active TB

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

- any cavitating lesion
- infiltrate or consolidation
- pleural effusion
- apical fibro-nodular/fibro-calcific lesions or apical micro-calcifications
- multiple/single pulmonary nodules/micro-nodules (non-calcified or poorly defined margins)
- isolated or multiple hilar, mediastinal or axillary mass(es)/lymphadenopathy (non-calcified)
- single/multiple pulmonary nodules/masses ≥1cm
- non-calcified pleural fibrosis and/or pleural effusion
- interstitial fibrosis/parenchymal lung disease/acute pulmonary disease
- notable apical pleural thickening (rough or ragged inferior border and/or ≥1cm thick at any point).

Minor findings, occasionally associated with TB disease

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

- Solitary granuloma (<1cm and of any lobe) with an unremarkable hilum
- Solitary granuloma (<1cm 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 line) 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 must 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 (<1cm thick at all points)
- unilateral or bilateral costophrenic angle blunting (below the horizontal line) if proven with additional views or ultrasound to represent thickening, not fluid
- calcified nodule(s) in the hilum/mediastinum with no pulmonary granulomata.

36.2 Strong suspicion of active TB

If Panel 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.

This field must only be marked 'yes' when the findings are convincing for active disease, for example, extensive infiltration or cavitation. This question must not be answered 'yes' simply if a suspicion of active disease exists.

If the CXR displays 'minor findings, occasionally associated with TB' or if in doubt, the Panel Radiologist must 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 must immediately refer the applicant for sputum testing.

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

36.3 Grading ‘A’ or ‘B’

Panel Radiologists are required to grade the CXR examination based on identification of a condition. Identification of a significant condition requires the radiology exam to be ‘B’ graded. For general guidance on grading, refer to Part B Section 33 ‘Grading ‘A’ or ‘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 must 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 must 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 extrapulmonary abnormalities (such as evidence of heart disease) must be ‘B’ graded. In cases where evidence exists of previous significant surgery, then the Panel Radiologist must provide details and grade the case ‘B’. Examples include:

- cardiac valve replacement
- sternal wiring
- vascular stents/shunts
- absent breast/s
- pacemaker
- artefact on the image.

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 in 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 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, attempt to send a substitute or seek investigation and treatment prior to attendance at the IME. The Instructions attempt to provide some guidance to Panel Physicians in order to minimise the impact of these types of behaviours.

38.1 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 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 tuberculous (MTB)
- testing for HIV disease.

38.2 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 must be recorded in the relevant section in eMedical or on the paper form 26.

The Panel Physician must 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 (pulmonary or extrapulmonary)
- 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 suggest 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 younger than two years of age, there can be a different presentation, and this 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 must be requested. These records must be comprehensive and include clinical findings, results of CXRs and any laboratory testing, drug regimen (including dosages) in generic form, comment about whether 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 must be uploaded into eMedical. If it is not in English, an accredited translation must be provided by the Panel Physician or qualified external third party.

Important details about previously treated TB must 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 must 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 extrapulmonary TB as a diagnosis. Panel Physicians must 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 must be uploaded if they are in digital format. If they are not in digital format, the CXR report or a comment on the previous CXR image must 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 (pulmonary or extrapulmonary) 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 is not required to be recorded in the history.

Visa applicants with a history of close household contact with active TB (pulmonary or extrapulmonary) within the past five years will require additional testing. A 719 examination (either Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) must 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 five years and under) must be referred for specialist review and CXR regardless of the result of the 719 examination.

Other contacts who are not visa applicants must 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 41 *Contact Tracing* of the Instructions.

38.3 Risk factors for reactivation of TB

Panel Physicians must 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[1]:

- recent TB infection (within the past five years)
- untreated or inadequately treated TB disease, including fibrotic changes on CXRs
- 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 must be recorded and the case ‘B’ graded (in most instances, eMedical will automatically grade the case ‘B’).

38.4 Indications for additional testing and Management of Latent TB Infection

Paediatric screening

Children from higher risk TB 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 MTB but does not have active TB disease. Testing for LTBI would normally mean that there is an intention to treat and treating doctors must have a low threshold for commencing treatment for LTBI, once active TB has been excluded. 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. The only exception to this is for close contacts of cases confirmed to be 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, must not delay submission of the case to the Department. All these cases must be ‘B graded’ and comment must be made indicating close household contact with active TB and prophylactic treatment for LTBI has/has not commenced.

[1] Systematic screening for active TB, WHO 2015

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

- Children aged 2 to under 11 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 2 to under 11 years, and:
  - are applying for refugee or humanitarian visas, or
  - are asylum seekers within Australia, and/or
- Children aged less than five 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 must undergo CXR examination and specialist paediatric review, regardless of symptomatology or clinical findings, or the result of the 719 examination.

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: https://immi.homeaffairs.gov.au/help-support/meeting-our-requirements/health/what-health-examinations-youneed

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 must be attached to the medical examination/eMedical. Applicants with a previous positive test as outlined must 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), a TST/ IGRA is not required. The medical history must be noted under the comments tab in the 719 examination (e.g. past history of TB) and the applicant may proceed directly to CXR. In these cases, the 719 examination can be finalised as incomplete noting the reason/s.

Note: *Previous BCG vaccination is not an exemption to TB screening test. BCG status must be recorded in the* General Supporting Comments. *IGRA is preferred over TST for those who have received a BCG vaccine.*

38.5 Health Care Worker and Health Care Student Screening

Health care workers from higher risk TB countries have an elevated occupational risk of TB exposure through the care of patients with active TB. Testing for previous exposure is designed to identify health care workers and health care students with LTBI that will require treatment or monitoring to prevent reactivation during their stay in Australia.

For health care workers and health care students LTBI screening, a 719 examination will be automatically generated if certain criteria are met on a person's visa application. Where a visa applicant indicates during the course of the IME that they intend to work or study as a health, aged or disability care worker and a 719 examination has not been added in eMedical, then the Panel Physician must add the 719 examination manually. Refer to *Module 9 – Examinations* on how to add the 719 examination.

Commencement of prophylactic treatment for LTBI must not delay submission of the case to the Department. All these cases must be 'B' graded and comments recorded indicating close household contact with active TB and whether prophylactic treatment for LTBI has/has not commenced.

Panel Physicians must provide pre-test counselling about the need for follow-up in Australia if the test is positive. Further counselling and offer of treatment will occur through referred specialist care in Australia.

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

- Visa applicants who declare their intention to work as, study or train to be a health care worker who are from a high risk TB country, and:
    - are a doctor, nurse, dentist or paramedic; or
    - are a health care worker who will have face to face contact with patients e.g. Chiropractors, Medical Administrators, Occupational Therapists, Radiographers, and
    - are applying for a permanent or provisional visa, or
    - are applying for a temporary visa of more than 6 months.
- Visa applicants who declare their intention to work as, study or train to be an aged care or disability care worker who are from a higher risk TB country, and
    - are applying for a permanent or provisional visa, or
    - are applying for a temporary visa of more than 6 months.

Any positive or indeterminate LTBI screening test for a health, aged or disability care worker or student will be 'B' graded automatically in eMedical, and further specialist follow up will be arranged in Australia.

Panel Physicians must provide a copy of the TST/IGRA report to the applicant (where available), or direct them to request a copy of their results from the relevant pathology provider (onshore cases).

Please also refer to Section 41 on Latent TB Infection**.**

38.6 Tuberculin Skin Test and Interferon Gamma Release Assay Tests

Testing for LTBI using either the TST (or Mantoux test) or the IGRA is required in any of the following three situations:

- history of close household contact of an index case
- for initial screening in children from higher TB burden countries
- for health care workers, students, trainees and other staff entering a health care, aged care or disability care facility that have face-to-face contact with patients or residents and are from higher TB burden countries.

Choice of TST or IGRA

Both TST and IGRA measure the immune response to MTB antigens. For the purposes of the IME either may be used. Parents or guardians must 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 must be aware that the TST may be positive if there has been previous 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.

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

TST and IGRA tests must be conducted prior to or at least four weeks after a live vaccine.

TST (Mantoux test)

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

Additional technical instructions may be provided by the Panel Physician's chosen provider, for example, pathology or pulmonology.

The TST must be administered by suitably qualified staff and be read between 48 and 72 hours. The result in millimetres (mm) induration must be recorded either in eMedical or on the paper form 26 and pathology reports uploaded into eMedical or attached to the paper file.

IGRA

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

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

Refusal to undertake IGRA or TST

Panel Physicians **must not** proceed to X-ray children where an IGRA and TST have been refused. If both are refused, the 719 examination must be recorded as incomplete with the drop-down comment selected to indicate that the applicant refused the testing.

The applicant **must not** be offered CXR (502 and 510 examinations) as an alternative.

Results of the TB test and what to do next

A TB test is considered positive if:

- The TST is greater than or equal to 10mm induration or the IGRA test is reported as positive
- The TST is greater than or equal to 5mm induration for those visa applicants who are close household contacts within the last five years or are immunosuppressed.

eMedical will automatically B-grade any positive or indeterminate IGRA results. For paper cases, B-grade must be assigned to cases with positive or indeterminate IGRA results.

All visa 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 aged under 11 years, a standard posterior-anterior (PA) projection is required as well as lateral view (510 examination). A lateral view is not required for applicants aged 11 years and over.

Where there is a positive 719 TB test, even if the CXR is normal and there are no other clinical signs, the Panel Physician must 'B' grade the case. For onshore applicants, the Panel Physician must refer the applicants to a local health chest clinic or respiratory specialist for ongoing care. If the 719 examination is negative, the case may be 'A' graded if there are no other significant conditions.

If the CXR shows signs consistent with active TB, sputum testing and pulmonologist (preferably paediatrician/chest physician) review are both immediately required and all these cases must be 'B' graded. For the purposes of the IME, an indeterminate test result **must be 'B' graded**, as further testing will be arranged when the applicant arrives in Australia.

39. Diagnostics

39.1 Sputum testing

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

1. Haemoptysis
2. any infectious or post infectious CXR changes in a person who has clinical signs or symptoms of TB
3. any infectious or post infectious CXR change in an HIV positive or otherwise immunocompromised person
4. radiological findings which indicate a strong suspicion of active TB
    a in adults, such findings include cavitation, soft infiltration or large effusion
    b in children, any infiltrate or subtle finding with a positive TB test is strongly suspicious of active TB.

In such cases, the radiology report must 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 must 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 unable to add a 603 examination on eMedical, they must contact the Department and seek assistance.

39.2 Sputum collection guidelines

Sputum collection must be supervised in a clinic or laboratory. It **must not** be collected at home. Ideally, sputum is to 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 must take place at the panel clinic. Panel Members must 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. The applicant must also be provided a surgical mask to prevent expelling potential infectious droplets.

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

39.3 Administrative arrangements

1. Information must be provided to the applicant prior to attendance in respect of time of attendance (morning collection is best practice) 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.
6. Safe storage and disposal of clinical waste.
7. 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.

39.4 Sputum collection

Sputum collection and laboratory processing of sputum samples must 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 SOPs 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 must discard any specimen found to be saliva and not sputum. In this case, the applicant needs to return for collection.

Applicants must 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 fourth deep breath, cough. The cough must 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 must 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) must 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 must be distilled or bottled. Large water cooler dispensers are not suitable as there is increased risk of contamination.

Instructions for applicants

- Rinse mouth with water and spit out.
- Cover mouth with a tissue.
- Sit on the stool provided.
- Hold the collection cup and take the top off.
- Take four very deep breaths and on the fourth deep breath, cough from deep in the chest/ stomach. The cough must use an abdominal contraction and not be just from the upper chest or throat.
- Hold your arm around your stomach and cough deeply.
- Collect the sputum in your mouth.
- Gently spill the sputum into the cup.
- Put the top on the cup and ensure it is tightly closed.
- Give the container to the staff in attendance.

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

Visual aids including posters or video demonstrations of collection techniques in the applicant's preferred language 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

If the laboratory is trained in sputum collection, nebulised saline induction can be utilised for applicants having difficulty with sputum collection who do not have any contraindications to the procedure. Precautions must be discussed, and consent obtained prior to sputum induction with strict infection control procedures followed (such as negative pressure room), as per laboratory guidelines. 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. A gastric aspirate, which is preferred for children, or bronchial washings can be considered if the collecting clinician is adequately trained in the procedure.

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 must:

- provide whatever sputum results are available with a comment that the applicant is unable to produce specimens
- attach the pulmonologist/ respiratory specialist/ chest physician 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.

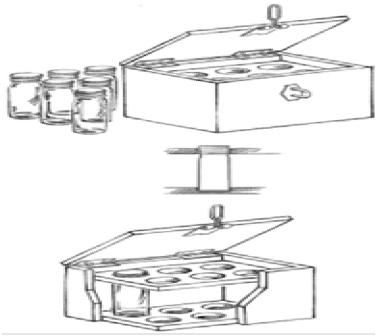
39.5 Sputum sample storage and transport requirements

Specimens **must never be pooled**. Each sample must remain separate in its own collection container at all stages of the process, including when specimens are being cultured.

The specimens are ideally collected onsite at the laboratory where it will be tested. If not, sputum samples must 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 must be stored in refrigeration at 4 degrees Celsius or 39.2 degrees Fahrenheit but **not** frozen, and protected from light. If the samples are to be transported to another site, careful procedures for packaging and shipment must be followed as detailed below.

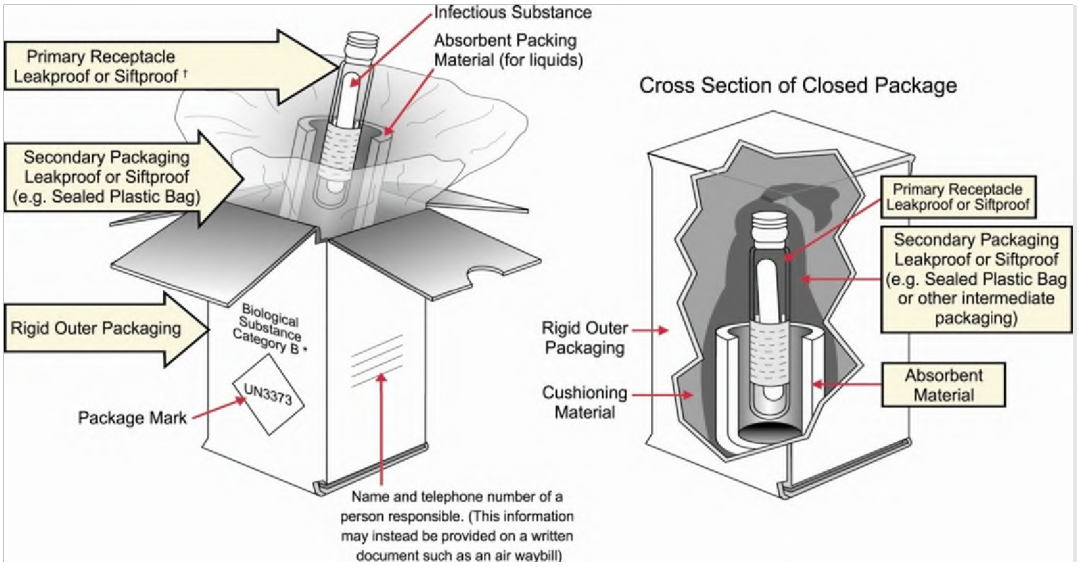
Specimens received in the laboratory must be processed within 24 hours of receipt.

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 over large distances by plane or other mode of transport, the specimens must be contained in three separate layers. 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.



39.6 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). Fluroescence Auramine stain (FAS) is preferred. A laboratory technician must 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.

39.7 Sputum Culture

Laboratories have the choice of using liquid or solid media for culture. The advantages of using the preferred 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 MTB complex level, is required. A single positive culture for MTB, in general, is considered to define active disease.

39.8 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, and pyrazinamide.

39.9 Second line Drug Susceptibility Testing (DST)

Mono resistance to either ethambutol or pyrazinamide does not routinely require second line DST but this may be performed depending on clinical circumstances.

Patients with resistance to isoniazid or rifampicin and any other resistance pattern, must go on to have second line DST. Second line DST must include testing for susceptibility to flouroquinolone, ethionamide, amikacin kanamycin, as well as linezolid clofazimine, and bedaquiline if available.

39.10 Use of molecular testing

The use of molecular or polymerase chain reaction (PCR) testing on sputum samples is becoming more widespread. Panel Physicians must remember that for the purposes of the Australian IME, smear and culture remains the reference standard.

The Cepheid Xpert® (MTB/RIF, MTB/RIF Ultra or MTB/XDR) assay and Hain GenoType® MTBDR plus (line probe) assay are considered less sensitive than culture. Cepheid MTB/RIB and MTB/RIF Ultra can determine resistance to rifampicin alone, Hain can determine isoniazid and rifampicin resistance and Cepheid MTB/XDR can determine resistance to isoniazid, fluroquinolones, amikacin and ethionamide. Sputum culture remains the gold standard test to determine the full drug susceptibility profile.

Panel Physicians that have access to PCR tests may utilise the assays for faster identification but not as a substitute for culture and drug susceptibility testing.

Instances where molecular tests may be considered include:

- 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.

For clinics determined by the Department to have limited access to a laboratory with sputum culture capability, or where transportation to such a laboratory risks the integrity of the sample, Xpert MTB/RIF, Xpert MTB/RIF Ultra or Xpert MTB-XDR may be used where the Department has specifically authorised the clinic to do so. In these instances, separate instructions will be provided to the clinic. In rare circumstances where molecular testing is authorised by the Department to be used, applicants with positive PCR results are still required to have three sputum samples collected and forwarded to a quality-assured TB reference laboratory for smear, culture and drug susceptibility testing, as per existing sputum collection guidelines.

39.11 Submitting Results and TB alerts

Sputum testing results must be submitted along with all specialist reports and the repeat CXR. For applicants with negative smear and culture and radiological stability, these are generally uploaded after three months. . If treatment has been recommended then results must 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:

- MDR or XDR-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) 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 must be submitted using the *Contact Us* tab in eMedical. Clinics not using eMedical must either use the Panel Physician Enquiry form 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–inConfidence'.**

Details required for notification of such cases are:
- family name
- given names
- date of birth (dd/mm/yyyy)
- HAP ID.

Panel Physicians must notify the Department even if the applicants indicate that they are withdrawing from the visa application process.

40. Treatment

40.1 Quality TB Management

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

1. ongoing staff training and development

2. systematic data collection and analysis
3. laboratory quality assurance and management
4. radiology quality assurance and management
5. National TB Program (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.

40.2 Decision to initiate Tuberculosis treatment

TB management of individual applicants must be supervised by the Panel Physician, even where the treating physician is an external provider. Panel Physicians must act as case managers to ensure that the requirements of treatment completion, public health notification, and resettlement needs are met. If permitted by local regulations (the country's NTP) and if limited access to a chest physician, suitably qualified and experienced Panel Physicians may manage the applicants directly. In these cases, there must 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 must 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 but 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 must be in the minority if good sputum collection techniques and high quality laboratories are used.

40.3 Isolation of applicants

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

1. symptomatic presentation that is highly consistent with pulmonary TB
2. smear-positive pulmonary TB
3. infectious applicants with infants or immunocompromised family contacts
4. applicants requesting assistance with treatment initiation due to disability or substance abuse or other prohibitive factors
5. suspected or confirmed MDR or XDR-TB.

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

Face masks must be worn by those with positive sputum smears until such time as smear conversion occurs, particularly by MDR cases. Applicants must be shown how to wear a surgical mask and instructed on the need to do this when outside the isolation area. Visitors are ideally received in open-air environments or other well-ventilated environments.

Where isolation facilities are not available, applicants must be educated on other means of reducing transmission risk, such as household isolation, to minimise family or social contact.

40.4 Treatment

Internationally recognised guidelines for treatment include those published by the World Health Organisation, American Thoracic Society, Centers for Disease Control and Prevention, Infectious Diseases Society of America, Canadian Thoracic Society, Ministry of Health New Zealand, UK National Institute for Health and Care Excellence, and Communicable Diseases Network Australia.

Information on TB treatment can be accessed through the Centers for Disease Control and Prevention (CDC), which describes standard regimens for pan-susceptible organisms. Dosing requirements for adults and children may be found in the link below.

See: https://www.cdc.gov/tb/topic/treatment/tbdisease.htm

Treatment of TB disease must occur in compliance with international standards and in cooperation with NTPs wherever possible. While 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. The initial regimen comprises of the four first line 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 trained health care worker supervises and documents the patient taking each dose of medication. DOT is the gold standard of care for all patients with TB disease as adherence to treatment reduces the risk 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, this must be documented in the file. The applicant's medical records must 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 must be present to illustrate the continuum of care and also to facilitate all treatment undertaken. This documentation is also important in assisting future clinicians when the applicant arrives in Australia.

The eMedical TB treatment forms (607 examination) must be completed 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 must be attached.

Non-Tuberculous *Mycobacteria* (NTM)

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

Treatment of Multi and Extensively Drug Resistant Tuberculosis

MDR-TB is caused by bacteria that are resistant to at least Isoniazid and Rifampicin. XDR-TB is a form of MDR-TB with additional resistance. The treating specialist must 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 psychosocial responses to treatment.

In addition to standard monitoring, monthly electrolyte profiles are advisable for applicants who are taking aminoglycosides or capreomycin due to their association with nephrotoxicity. Applicants must also 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 para-aminosalicylic acid (PAS) or ethionamide. Extended treatment with ethambutol will necessitate ongoing monitoring of vision.

CXRs must 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 must 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 may be considered to be 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 period of time. In these cases, Panel Physicians must 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 must then finalise the case as "incomplete" indicating this.

40.5 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 treatment program. 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 may 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, 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

Two sputum specimens must be collected and submitted for AFB microscopy and MTB culture once a month during therapy, until cultures are negative for two consecutive months. Two specimens must be collected at the end of therapy if the applicant's treatment is not being provided by DOT at a panel clinic.

Resistance to one or more drugs (but susceptible to isoniazid or rifampicin)

Two sputum specimens must be collected and submitted for AFB microscopy and MTB culture once a month during therapy, until cultures are negative for two consecutive months. Two sputum specimens must also be collected and submitted for AFB microscopy and MTB culture at the end of therapy.

MDR-TB and XDR-TB cases

MDR-TB cases require two sputum specimens to be collected and submitted for AFB microscopy and MTB culture once a month during therapy. Two sputum specimens must be collected and submitted for AFB microscopy and MTB culture at the end of therapy.

Culture negative cases

For cases with no drug susceptibility testing results (culture negative cases), one sputum specimen must be collected and submitted for AFB microscopy and MTB culture once a month during the entire course of therapy. Two sputum specimens must be collected and submitted for AFB microscopy and MTB 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 must 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
- events that require notification to Panel Physician
- minimum content of treatment certificate.

40.6 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:

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

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

- All treatment records including the DOT record.
- All sputum test results.
- End of treatment CXR.
- Report from the final clinical review by the specialist.

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

40.7 Health Clearance at end of Treatment

The MOC provides the final opinion about whether the applicant can be considered free of TB. Panel Physicians must submit records confirming that applicants were treated according to the Instructions. Sputum processing and treatment must be conducted using an accredited laboratory or clinic), with appropriate clinical oversight and with DOT provided by a health care worker. Health clearance is expected to be received in a timely manner. Panel Physicians who are unable to provide such records, for example, if the applicant was treated at an external provider, must advise applicants that their health clearance may be deferred for a 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 at an external facility that is not affiliated with the panel clinic.

41. Contact Tracing

41.1 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. This process must include counselling of the applicant who is positive (prior to commencing the tracing as far as possible).

41.2 Which contacts must 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.

41.3 Notification of relevant authorities

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

41.4 Panel Physician responsibilities

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

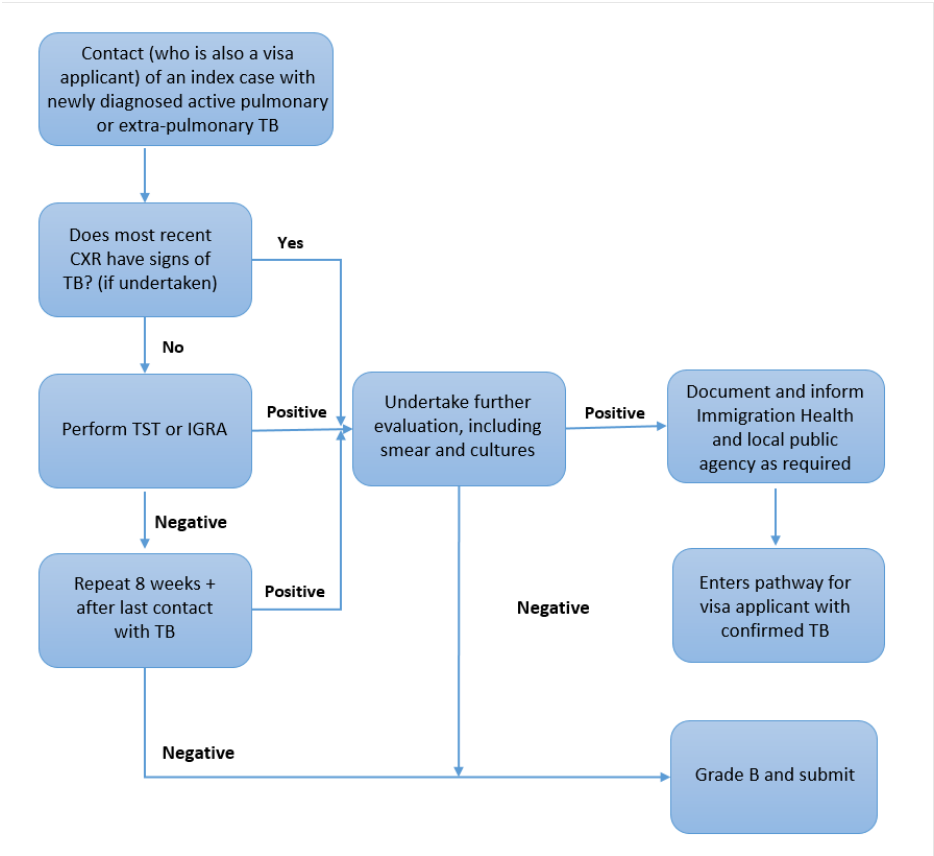
Contact tracing in the IME setting must be focused on contacts with other visa applicants that fall into the contacts definition. For visa applicants, it is the responsibility of the Panel Physician to undertake contact tracing. One of the first activities is to review latest CXRs (if available).

41.5 Further evaluation

Further investigations on visa applicants who are contacts include TST or IGRA. If the TST or IGRA is negative, then this test must be repeated eight weeks after exposure ends by Panel Physicians for visa applicants.

If TST or IGRA is positive, then the contact must 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 a visa applicant, of confirmed TB cases.



41.6 Latent TB Infection

LTBI is a condition where a person is infected with MTB 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 must occur after the applicant arrives in Australia and not be initiated by Panel Physicians. However, if the applicant decides to undergo LTBI treatment, this may be initiated in the country of origin, but the applicant must 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 must be initiated in the applicant's home country such as:

- children who are immunocompromised
- children aged five years and under who are known to be close household contacts of a case of TB (pulmonary or extrapulmonary) 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:

- four months rifampicin (RIF)
- six to nine months isoniazid (INH) which has higher liver toxicity risk and lower treatment completion rates than shorter rifampicin-base regime

The choice between the above will depend on the resistance pattern of the index case, if known. INH mono-therapy is advised if pan-susceptible infection or drug-to-drug interactions with rifampicin 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

42.1 Notification of local public health authorities

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

- comply with the requirements 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 Program.

42.2 Post-arrival medical follow up

Panel Physicians must 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: Psychosocial Management of TB Patients[1]

A diagnosis of TB carries with it a risk of negative psychosocial 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 may 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 psychosocial 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.

A1 Support at diagnosis

Counselling must be provided to all applicants identified as requiring TB treatment as indicated above. They must be reassured that TB can be treated. It must 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 must be identified to assist and support the applicant during treatment and observe for physical or psychological deterioration. To improve wellbeing, addressing diet, smoking habits or substance abuse must be promoted.

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

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

A2 During Treatment

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

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

Counselling must be made available on a weekly basis to all applicants who wish to utilise this service. Counselling must 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.

Alternative providers of psycho-social support (such as Non-Government Organisations in refugee camps) must 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 must be reviewed by a physician at least weekly. Isolation must be discontinued as soon as public health management needs allow, and must not be prolonged for other reasons.

Diversionary activities must 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 must be encouraged to help support each other through treatment.

Multi-disciplinary staff meetings regarding TB cases must 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, must be discussed in entirety during these meetings, including a review of applicant mental state and psychosocial management and consideration of relevant family members. The importance of team effort, information sharing and coordination among staff caring for TB patients must be continuously highlighted.

Emphasis must be made on increasing the capacity of staff to monitor overall applicant condition, including recognising mental changes and warning signs. Personnel must understand the need to listen and respond to individual needs rather than limiting interactions to purely medical information.

Appendix B: TB Infection Control

Following the COVID-19 pandemic, it is acknowledged that there are some symptoms and infection control practices that are shared between COVID-19 and TB. Staff must continue to be vigilant about both.

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.

B1 Awareness of transmission and infection control

Educational material on TB infection control must 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” must be displayed with tissues and masks made available in case of cough. Applicants must be routinely asked about cough on entering the facility. Applicants who are coughing must be provided with masks, separated from general client flows and prioritised for medical attention.

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

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

B2 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 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 must 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 must be directed from low to high concentrations of infectious particles. Where possible, staff must 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.

B3 Management of infectious applicants

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

These applicants must 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 must occur in a segregated area, as must 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 must 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 must also be in place and monitored by the infection control officer.

B4 Personal protective equipment

Staff working with infectious applicants must wear P2/N95 respirator masks or equivalent masks at all times whilst in areas of potential exposure. Staff must be instructed in correct mask fitting and must not have facial hair which might compromise mask fit. Masks must be replaced regularly, and immediately if wet or damaged. Masks must not be touched while being worn and hand hygiene must be performed upon touching and disposing a used mask.

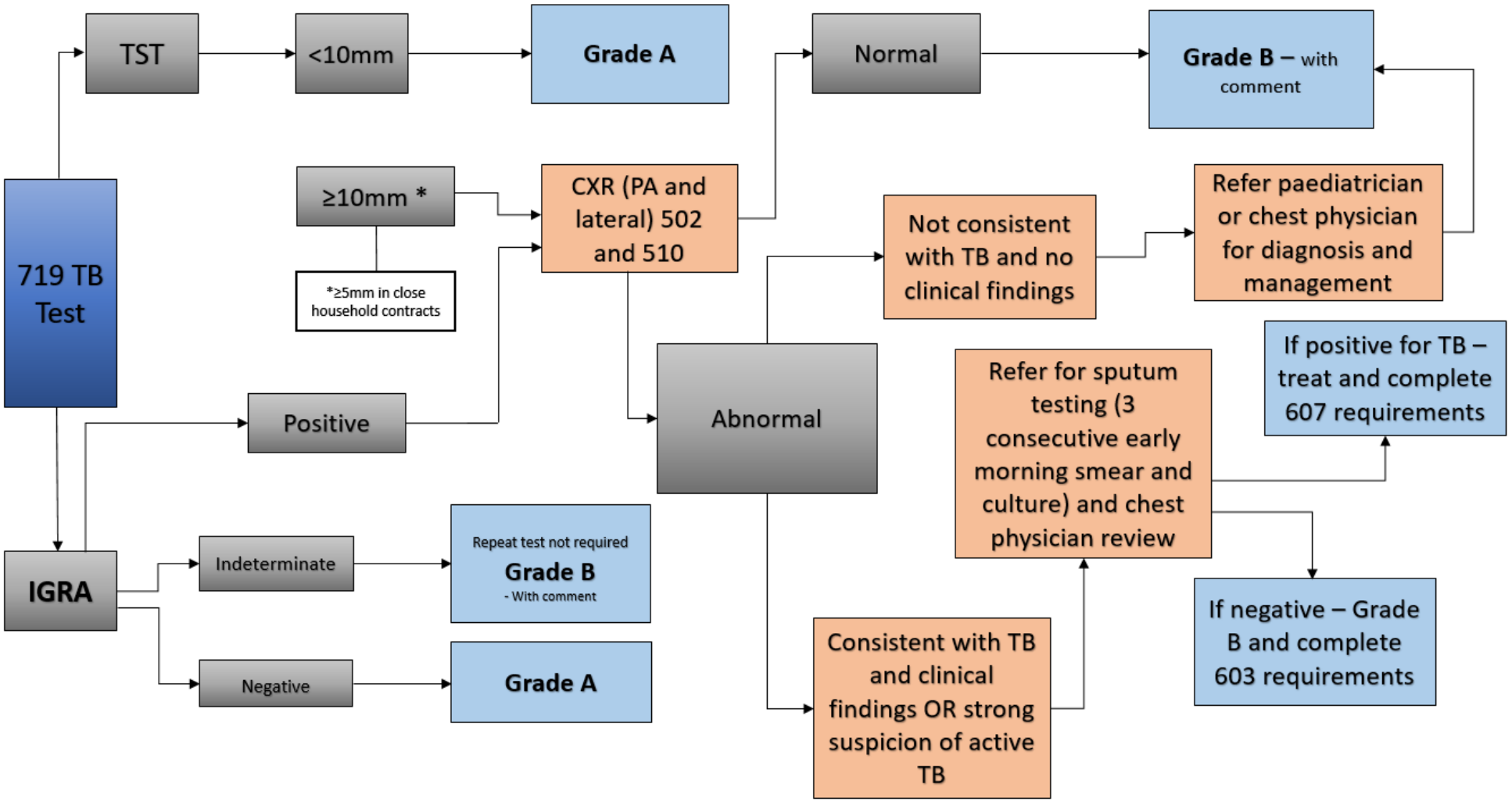
Gloves must be worn by staff handling infectious or potentially infectious materials including used tissues or face masks.

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

B5 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 must inspect the site and review the disposal process at least annually.

Appendix C: Children (Aged 2 to 10 years) TB screening algorithm



Appendix D: 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**.

Arabic: للفحص الطبي الخاص بك تحتاج إلى خلع كل ملابسك ولكن يرجى الإبقاء على ملابسك الداخلية

French: Pour votre examen médical, vous devez vous déshabiller mais gardez vos sous-vêtements.

Indonesian: Untuk pemeriksaan medis, Anda perlu melepaskan semua pakaian, kecuali pakaian dalam.

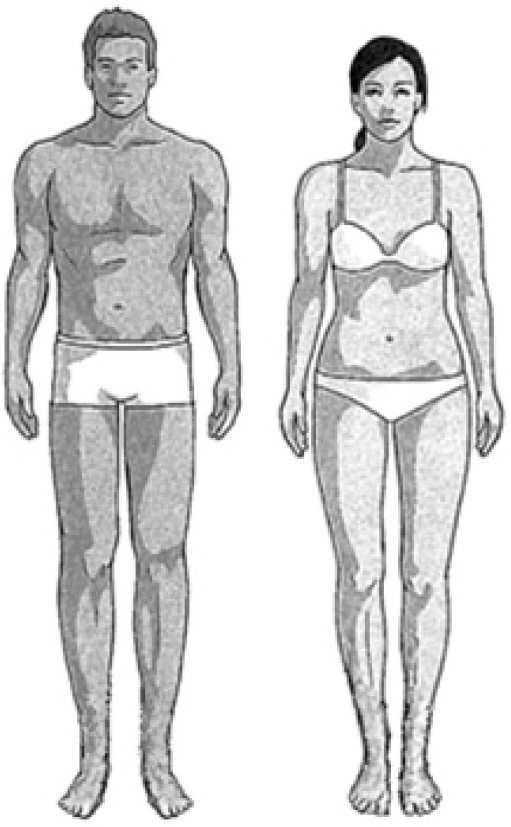
Korean: 검사를 받기 위해서 모든 옷을 벗으셔야 합니다만, 속옷은 입고 계시기 바랍니다.

Mandarin: 您需要脱掉所有的衣服来进行体格检查，但是请穿着内衣裤。

Spanish: Para el examen médico debe sacarse toda la ropa y quedarse en ropa interior.

Tagalog: Para sa inyong medikal na pagsusuri, kailangan ninyong hubarin ang lahat ng inyong damit subali't iwanang nakasuot ng inyong panloob na pang-ibabang kasuotan.

Vietnamese: Khi khám nghiệm y khoa, quý vị cần trút bỏ quần áo ngoài, nhưng hãy mặc quần áo lót.



Please also remove your shoes and socks.

Appendix E: Guidelines for Specific Medical Conditions

Note: *Lists are non-exhaustive. Clinical judgement must be exercised for conditions that are not listed.*

Condition	Approach
Arthritis	**'A' Grade:** Minor disease - no interference with function. **'B' Grade:** Significant disease affecting ADLs or work capacity or requiring management with disease modifying anti-rheumatic drugs (DMARDs), or likely to require surgery in the near future. Perform functional assessment (903 ADL exam) and document treatment requirements. Specialist report not required unless considered appropriate and requested.
Back pain	**'A' Grade:** No functional impairment. **'B' Grade:** ADLs and/or work capacity impaired. Perform functional assessment (903 ADL exam) and provide treatment details. Specialist report may be requested.
Body Mass Index (BMI)	**'A' Grade:** Stable weight, or obesity without complications **'B' Grade:** Unexplained weight loss, or obesity with complications known or suspected. Provide details, relevant test results, and estimation of treatment needs.
Cancer	**'A' Grade:** No recurrence ≥ five years post -treatment, with no symptoms or ongoing functional impairment **'B' Grade:** New diagnosis, recurrence exists, or if < five years since treatment. Recent specialist report within the last 12 months required. Panel physicians must upload any treating doctor reports that the applicant has with them at the time of the IME.
Cardiac murmur	**'A' Grade:** Asymptomatic, healthy applicant with normal X-ray where pathology has been excluded. **'B' Grade:** Symptomatic or evidence of cardiac failure. Cardiology opinion and echocardiography required.
Chest X-ray changes	**'A' Grade:** Anatomical variations and benign changes. **'B' Grade:** All pathological, infectious, or post-infectious changes.
Diabetes	**'A' Grade:** If stable with no suspicion or evidence of end-organ damage. **'B' Grade:** End-organ complications known or suspected, especially renal impairment, peripheral neuropathy or vascular changes. Provide relevant investigation results. Specialist report not required unless requested.
Frail elderly	**'A' Grade:** Reasonably fit with no cognitive or functional impairment. **'B' Grade:** Evidence of cognitive or functional impairment. MMSE/ ADL assessment required. Document medical issues and treatment needs.
Gastrointestinal conditions	**'A' Grade:** Appendectomy, cholecystectomy and hernia repair scars, uncomplicated peptic ulcer disease. **'B' Grade:** Inflammatory bowel disease, jaundice, hepatomegaly, ascites, peripheral signs or symptoms of liver disease. Investigations or specialist reports may be required. See also **Hepatitis**.

Condition	Approach
Hearing loss	**'A' Grade:** Reasonable hearing with or without hearing aids. **'B' Grade:** Hearing loss affects daily function and is uncorrected by hearing aids. Obtain specialist report for children and young adults including comment on whether cochlear implant may be required.
Hepatitis B Surface antigen positive	**'B' Grade in all cases:** Perform LFTs and Hepatitis C test. Complications or abnormal liver function test results require gastroenterology assessment including ultrasound and/or fibroscan.
Hepatitis C antibody positive	**'B' Grade in all cases:** Perform LFTs and Hepatitis B and HIV test. Complications or abnormal liver function test results require gastroenterology assessment including ultrasound and/or fibroscan.
HIV seropositive	**'B' Grade in all cases** once confirmatory assay (Western blot/immunoblot) result is available. If not available, retest with different EIA method to original test. If an applicant is outside Australia, a positive 707 exam result will generate a requirement for an HIV Specialist Report (eMedical code 722). CD4 and viral load must be included in the specialist report. A Hepatitis C test is also required to be performed.
Hypertension	**'A' Grade:** Stable with no evidence of end-organ involvement. **'B' Grade:** Unstable and/or end-organ involvement suspected. If repeat BP >160 systolic and/or diastolic >100, and the applicant does not have a valid eGFR, eMedical will automatically generate a request for an eGFR (705 examination). If raised, specialist report required.
Impaired Kidney Function	**The grade will be auto-managed by eMedical.** **For paper cases: 'B' Grade**: all results where eGFR is <60 **For pregnant applicants: 'B' Grade**: all results where serum creatinine is >1.02mg/dL (90 µmol/L)
Intellectual disability	**'B' Grade in all cases:** Document nature and degree of disability. Perform developmental age assessment in children and young adults. Consider specialist assessment.
Ischaemic heart disease	**'A' Grade:** Stable and asymptomatic. **'B' Grade:** If unstable or symptomatic, refer for cardiology assessment
Latent TB Infection	**'A' Grade:** TST < 10mm or IGRA negative if no close household TB contact. **'B' Grade:** TST $\geq$ 10mm, IGRA positive or indeterminate, and all close household contacts of index cases no matter the result of LTBI test.
Neurological disorders (for example, MS)	**'A' Grade:** Minor sequelae of previous disease (for example, deformity from childhood polio) that has no significant functional impairment **'B' Grade**: all significant and/or progressive neurological diagnoses, (for example MS, inherited disorders, cerebrovascular disease) See also 'Physical disability' below.

Condition	Approach
Obesity	See also **Body Mass Index (BMI)**
Physical disability	**'A' Grade:** Mild, without restriction on daily living or employment capacity. **'B' Grade:** Significant disability impacting daily living or employment capacity. Perform functional assessment, including employment history if working age. Specialist report not required unless requested.
Pregnancy	HBsAg testing is required if the applicant is intending to deliver in Australia. **'A' Grade:** CXR is available and normal, or applicant is from lower risk country **'B' Grade:** No CXR is available in applicants from higher risk countries (cases must generally be deferred until CXR is available)
Psoriasis	**'A' Grade:** Skin involvement only **'B' Grade:** Systemic complications such as arthritis are known or suspected.
Surgical history	**'A' Grade:** If past surgery has no effect on current health or function, scars need not be recorded **'B' Grade:** If past surgery impacts current health or function or further surgery is required.
TB – active disease	**'B' Grade in all cases:** Refer applicant for sputum collection and specialist assessment. Obtain HIV result if not already performed.
TB – previous disease or other eg. Household contact or abnormalities	**'B' Grade in all cases: Document detailed history as per Section 38 – Screening previous treatment. Submit medical file without sputum collection unless sputum collection is required as a result of 502 examination and/or MOC opinion.**
Thyroid	**'A' Grade:** All benign thyroid disorders **'B' Grade:** If malignancy known or suspected. In that case, further investigation such as an ultrasound and/or specialist report required.
Visual impairment	**'A' Grade:** VA > 6/24 in better eye (with use of corrective lens or pinhole). **'B' Grade:** If VA ≤ 6/24 in better eye, eMedical will auto 'B' grade. Add comment on the cause of poor visual acuity and applicant's functional capacity. **Document the causes of poor visual acuity in the 501 exam.**

Appendix F: Chart of Early Child Development Milestones

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:

ACTIVITIES TO BE OBSERVED ON EXAM	ACTIVITIES RELATED BY PARENTS OR CAREGIVER
1 - 2 MONTHS OF AGE	
Holds head erect and lifts head	Recognizes parents
Regards faces and follows objects through visual field	Engages in vocalizations
Becomes alert in response to voice	Smiles spontaneously
3 - 5 MONTHS OF AGE	
Grasps cube - first ulnar then later thumb opposition	Laughs
Reaches for and brings objects to mouth	Anticipates food on site
Plays at making sounds	Turns from back to side
Sits with support	
6 - 8 MONTHS OF AGE	
Sits alone for a short period	Rolls from back to stomach
Reaches with one hand	Is inhibited by the word "NO"
First scoops up a small object then grasps it using thumb and opposition	
Imitates "bye-bye" and babbles	
Passes object from hand to hand in midline	
9 - 11 MONTHS OF AGE	
Stands holding on	Walks by supporting self on furniture
Imitates pat-a-cake and peek-a-boo	Follows one-step commands e.g., "Come here" or "Give it to me"
Uses thumb and index finger to pick up small object	
1 YEAR OF AGE	
Walks independently	Points to desired object
Says "mama" and "dada" with meaning	Says 1 or 2 words
Can use a neat pincer grasp to pick up a small object	
Releases cube into cup after demonstration	
Gives toy on request	
18 MONTHS OF AGE	
Builds tower of 3-4 cubes	Walks up and down stairs
Throws ball	Says 4-20 words
Scribbles spontaneously	Understands a two-step command
Seats self in chair	Carries and hugs doll
Dumps small objects from bottle	Feeds self

ACTIVITIES TO BE OBSERVED ON EXAM	ACTIVITIES RELATED BY PARENTS OR CAREGIVER
ACTIVITIES TO BE OBSERVED ON EXAM	**ACTIVITIES RELATED BY PARENTS OR CAREGIVER**
24 MONTHS OF AGE	
Speaks short phrases, 2 words or more	Verbalizes toilet needs
Builds tower of 6-7 cubes	Turns pages of book singly
Points to named objects or pictures	Plays with domestic mimicry
Stands on either foot alone and jumps off floor with both feet	Pulls on simple garment
30 MONTHS OF AGE	
Walks backward and begins to hop on one foot	Helps put things away
Holds crayon in fist - copies a crude circle	Puts on clothing
Points to objects described by use	Carries on a conversation
Refers to self as "I"	
3 YEARS OF AGE	
Holds crayon with fingers, copies circle	Dresses with supervision
Builds tower of 8 cubes and imitates 3-cube bridge	
Gives first and last name	
3 - 4 YEARS OF AGE	
Climbs stairs with alternating feet	Feeds self at mealtime
Begins to button and unbutton	Takes off shoes and jacket
Responds to command to place toy in, on, or under table	
Knows own sex	
Gives full name	
4 - 5 YEARS OF AGE	
Runs and turns without losing balance	Self-care at toilet
May stand on one leg for at least 10 seconds	Dresses self except for tying shoes
Buttons clothes	
Knows the days of the week	

Source: Immigration, Refugees and Citizenship Canada. Chart of Early Childhood Development.

Appendix G: Activities of Daily Living (ADL) Assessment (903 examination)

Applicant's Name:		**Applicant's DOB:**		
1. Self-care: Can the client perform the following without help				
	Yes, with ease (no devices or prior preparation)	Yes, with difficulty (limited, with devices or prior preparation)	No, some help required (assisted)	No, totally dependent (unable)
1.1 Feed/drink	☐	☐	☐	☐
1.2 Dress in clothes	☐	☐	☐	☐
1.3 Grooming	☐	☐	☐	☐
1.4 Wash/bathe (including transfers)	☐	☐	☐	☐
1.5 Toilet use (including transfers, dressing, hygiene)	☐	☐	☐	☐
		Note degree of assistance		
2. Sphincter control: Please confirm the client's level of continence				
	Completely voluntary/continent	Urgency or use of catheter/appliance	Some accidents	Frequent accidents/incontinent
2.1 Bladder control	☐	☐	☐	☐
2.2 Bowel control	☐	☐	☐	☐
	Note urgency or use of catheter/appliance		**Note frequency of accidents**	

3. Mobility/locomotion: Can the client perform the following without help				
	Yes, with ease (no devices or prior preparation)	Yes, with difficulty (with devices or prior preparation)	No, some help required (assisted)	No, totally dependant (unable)
3.1 Transfer bed to chair/wheelchair and back	☐	☐	☐	☐
3.2 Walk or independent with wheelchair 50 metres – level	☐	☐	☐	☐
3.3 Stairs, up/down one floor	☐	☐	☐	☐
NB: In the context of the functional assessment, devices include such aids as feeding cuffs, special cutlery dishes, dressing aids, transfer boards/poles.				

4. Please record the client's level of				
	Full	**Moderate**	**Minimal**	**None**
4.1 Comprehension	☐	☐	☐	☐
4.2 Communication and expression	☐	☐	☐	☐
4.3 Social interaction	☐	☐	☐	☐
4.4 Cognition, memory and orientation	☐	☐	☐	☐
		If minimal to moderate cognitive impairment, please perform 901 Mini Mental State Exam		

5. I have assessed the client's overall level of self-care as					
☐ **Independent**		☐ **Partial assistance required**		☐ **Full assistance required**	
Current residence	☐ Own home	☐ Relative's home	☐ Residential care	☐ Hospital	☐ Other (please specify)
Time at above	Years:		Months:		
Current Caregiver Designation:					

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Printed name and signature of examining physician Date (dd/mm/yyyy)