Australian Government

Department of Immigration and Citizenship

Instructions for medical and radiological examination of Australia visa applicants

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Instructions for medical and radiological examination of Australia visa applicants

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Contents

Part A: What you need to know about being on the panel

The Australian Government welcomes you to the panel member network. These instructions will help you understand the:

- role and obligations of a panel member
- support that you can expect to receive
- standard of health examinations required
- standard of practice facilities required

1. Panel management

1.1 The Health Operations Centre

The Health Operations Centre (HOC) processes offshore medical results and assists panel members, Australian missions and health services in Australia with information, support and expert advice.

HOC is where medical results are referred to when review by a Medical Officer of the Commonwealth (MOC) is required.

MOCs determine whether visa applicants meet health criteria, based on reports provided by panel doctors, panel radiologists and specialists.

HOC is responsible for:

- managing panel doctors and radiologists
- auditing the quality and integrity of the panel's work
- managing complaints
- arranging audit visits to panel members
- responding to medical and administrative queries from panel members.

1.2 HOC can be contacted on any immigration health matter:

Website:	www.immi.gov.au/gateways/panel_doctors/
Email:	Health.Operations.Centre@immi.gov.au
Telephone:	+61 2 8666 5777
Fax:	+61 2 8666 5900 / 5901
Contact hours:	Monday-Friday 9 am-4 pm (Australian Eastern Standard Time)
Mail:	GPO Box 9984 Sydney NSW 2001 AUSTRALIA
Courier:	Level 3, 26 Lee St Sydney NSW 2000 AUSTRALIA

Panel doctors and radiologists are to refer to the 'Where to send Australian visa medicals' table available on the Panel Doctors Gateway website to identify which health assessments are to be sent to HOC and which are to be sent to the local processing office.

1.3 The Australian Mission (the post)

The Australian mission responsible for your region, such as an Australian Embassy, Consulate General, High Commission or visa office, is referred to as a 'post'. Although HOC retains primary responsibility for managing the panel member network, posts take an active role in assisting HOC with:

- monitoring local health issues and trends
- monitoring the performance of panel doctors and panel radiologists
- providing an alternative contact point for panel members in emergencies
- conducting site visits, and
- processing results of health examinations conducted by panel members for certain visas.

2 What are Australia's health criteria?

The Department of Immigration and Citizenship (DIAC) administers Australia's immigration and entry programs. Australian migration legislation requires that all applicants seeking a visa to travel to, or to remain in, Australia must meet prescribed health criteria. These criteria are meant to protect the Australian community's:

- public health and safety
- expenditure on health and welfare, and
- access to health services.

This means that an applicant is to be free of:

- tuberculosis
- a disease or condition that is, or may result in the applicant being a danger to the Australian community
- any disease or condition which, during the applicant's stay in Australia, would be likely to:
    - result in a significant cost to the Australian community in the areas of health care or community services
    - prejudice the access of an Australian citizen or permanent resident to health care or community services, and/or
    - prevent their departure from Australia if their proposed visit is temporary.

3 Australian immigration documentation

3.1 How to determine what health assessment is required for each applicant

The health assessment required for each applicant depends on a number of factors: type of visa applied for, intended length of stay, country of citizenship and residence during the previous five years, age, and any health issues the Australian Government considers of special significance.

Note:

- Applicants who are applying for a temporary visa that is intended to lead to permanent stay should be assessed according to the requirements for permanent visa applicants. These visa classes are known as 'Provisional'.
- Please check the health requirements for temporary and permanent visa applicants outlined in the information forms 1163i Health requirement for temporary entry to Australia and 1071i Health requirement for permanent entry to Australia.

4 Which forms need to be completed?

The standard forms for panel doctors and radiologists to report and record comments in English are:

Form 26	Medical examination for an Australian visa (see part B: page 28).
Form 160	Radiological report on chest x-ray of an applicant for an Australian visa (see part C: page 46).
Forms 26EH and 160EH	Downloaded with electronic visa applications. Complete as per forms 26 and 160.
Aged Visitor Health Check	Assessment of visitor applicants 70 or more years of age (see below).

4.1 Aged Visitor Health Check

Panel doctors may be required to examine elderly applicants (70 or more years of age) to assess their fitness to travel to Australia, to remain well for the proposed length of stay, and to return to their home country. The purpose of the examination is to identify the level of functional independence and to exclude unstable medical conditions.

The applicant will provide the panel doctor with a copy of the Aged Visitor Health Check form given to them by their visa case officer.

The assessment is designed to identify any current significant medical conditions, or a history of significant medical conditions, including tuberculosis; dementia; severe cardiac or respiratory disease; or any condition that may require dialysis treatment, cancer treatment, or treatment involving the use of blood products. In certain cases the applicant will also be required to undergo a chest x-ray, for example, for certain visa classes, or where clinically indicated.

The Aged Visitor Health Check form comprises questions, some of which require ‘yes/no’ answers and others a comment. If additional space is required please add an attachment. All questions must be answered, and all requisite tests completed before an applicant’s case will be considered further.

Please note that a completed report is valid for six months from the date of the examination.

You may also like to view the relevant guidelines regarding ‘fitness to fly’ for the international airline(s) in your country.

5 Roles and responsibilities

5.1 Panel members

Panel members include panel doctors who undertake medical examinations, and panel radiologists who undertake radiological examinations. Together they make up the panel member network.

5.2 Panel doctors

The Australian Government appoints individual doctors as panel doctors. In general, medical clinics as their own entities are not approved for appointment. However, more than one doctor may be appointed at a clinic. While the appointment is a personal one, the Australian Government takes account of the integrity of the entire practice or entity in which the panel doctor works, including other doctors, staff members, facilities, laboratories and radiology practices. Appointed panel doctors must not allow other doctors to conduct immigration health examinations as a substitute or locum without prior written consent of HOC.

5.2.1 Panel doctors are to:

- personally undertake the complete health examination of applicants
- ensure the quality and integrity of the entire examination process
- provide accurate and complete reporting on the health of visa applicants
- ensure that pathology laboratories and TB testing and treatment clinics have access to and understand the instructions
- provide an impartial recommendation on behalf of the decision making body (DIAC)
- advise applicants of any abnormalities of clinical significance found during the examination, and
- refer applicants requiring treatment to their usual treating doctor.

5.2.2 Panel doctors are not:

- authorised to oversight health examinations conducted by non-panel doctors
- permitted to provide treatment to applicants except in emergencies
- responsible for providing opinions as to whether applicants meet the health requirement.

5.2.3 The panel doctor examination of an applicant includes:

- confirming that the person presenting for the examination is actually the visa applicant
- ensuring that for all applicants 11 or more years of age (for permanent or long-term temporary entry) a panel radiologist completes form 160
- performing a dipstick urinalysis for the presence of albumin, glucose and blood for applicants 5 or more years of age who are undergoing a health examination
- personally taking or assuming responsibility for secure specimen collection within the clinic
- arranging for appropriate security or coding procedures to be incorporated into the testing process
- arranging for secure delivery methods for specimens that require transport to various sites as specimens never should be given to applicants for transport
- reviewing form 160 to take into consideration the findings when making a recommendation on form 26. Include form 160 and film with form 26 when submitting the results to DIAC
- completing all parts or items of form 26 or the Aged Visitor Health Check form, and
- sending all original reports, including any blood tests, smears and cultures or other diagnostic test results to the appropriate processing office.

5.3 Chief panel doctors

In exceptional circumstances, at the discretion of HOC, all physicians working at a clinic or institution may be authorised to conduct DIAC medical examinations through the appointment of a supervising doctor. The supervising panel doctor is known as the chief panel doctor. HOC lists individual doctors conducting immigration medical examinations at clinics where a chief panel doctor is appointed.

5.4 Locums

Panel locums can perform immigration medical examinations on an ongoing basis to provide coverage during periods of extended leave or high demand.

When a panel member plans extended leave they should provide four weeks notice to HOC. Depending on local panel coverage, HOC may approve the appointment of a locum or inform the panel doctor/post of the period during which applicants need to be referred to alternative panel clinics. If a panel member nominates a doctor as their locum they should be satisfied that the doctor has the qualifications, experience, knowledge and skills to perform the immigration medical examinations. An effective handover of procedures must be arranged to ensure continuity of applicant service. Panel doctors should inform HOC of their locum's regular periods of activity.

The documentation required is the same as a permanent panel appointment. If you would like further information on appointing a panel locum, please contact HOC.

On occasion, where HOC needs to expedite the appointment of a doctor and complete documentary evidence is unavailable or is planning to conduct local onsite audit visits, a panel member may be appointed on a probationary 'locum' basis pending a permanent appointment. A permanent appointment will ensue once the complete documentation is provided, or following a positive onsite assessment of the clinic by HOC.

5.5 Panel radiology clinics

Radiology clinics are appointed to the panel as a unit. Within each clinic, a chief radiologist is designated and must nominate any other radiologist who will undertake immigration radiological examinations at their facility.

Where a radiology practice has multiple branches, HOC will generally appoint a single branch clinic to focus exclusively on immigration radiology examinations. This arrangement supports the training of staff in integrity checking procedures and the correct forwarding of examination results. The chief radiologist should be located at this site most days of the week. Panel inclusion of additional branches will be at the discretion of HOC and may entail the appointment of a chief radiologist at each location.

5.6 Chief radiologists

The appointed chief radiologist for a practice has responsibility for the training and supervision of all panel radiologists conducting Australian immigration radiological examinations at that location, including ensuring the quality of reports. Under the direction of the chief radiologist, clinic staff are required to follow identity checking procedures and familiarise themselves with the forwarding procedures for the radiological examination results.

5.6.1 Chief radiologists are to:

- ensure that all panel radiologists undertaking Australian visa radiological examinations are suitably qualified as specialists in any branch of radiology and are registered to work in their country of practice
- receive feedback regarding panel radiologists and staff in their clinic and work with HOC in resolving cases or issues of concern
- exclude individual panel radiologists from conducting Australian visa radiological examinations if they are suspended or removed from the panel
- ensure that radiological examinations for DIAC clients are conducted only at the appointed site
- put into practice and monitor the identity-checking procedures of Australian visa applicants

- ensure their clinic forwards the radiological examination form and chest x-ray film:
    - directly to the panel doctor if the client is also required to undergo an Australian immigration medical examination, or
    - directly to the appropriate DIAC processing office, and
- circulate HOC communication to panel radiologists and clinic staff, and advise HOC of their clinic's contact details, capabilities and working arrangements, including any alterations required.

5.6.2 Chief radiologists and panel radiologists are to:

- conduct radiological examinations for certain visa applicants 11 or more years of age
- conduct radiological examinations for applicants under 11 years of age suspected of having tuberculosis following referral by a panel doctor
- provide accurate and complete reporting on the health status of visa applicants (determined by radiological examinations)
- provide an impartial recommendation on behalf of the decision making body (DIAC)
- ensure that the completed form 160 clearly identifies the name of their radiology clinic
- advise applicants of any abnormalities of clinical significance found during the examination, and
- refer applicants requiring further treatment to their usual treating doctor or an appropriate specialist.

6 Conditions of appointment

Panel members are not employees of the Australian Government. They do not represent the Australian Government and no contractual arrangement exists. Panel doctors are required to comply with all conditions of appointment issued to them by the Australian Government, 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 attend the panel doctor of their choice. The Australian Government cannot accept any responsibility for any loss of business or patronage at a clinic, whether as a result of changes to the migration program, applicants' choices, suspension or removal from the panel, or for any other reason. Panel members are not to receive or accept service or incentive fees of any kind from third parties, such as migration agents or referral agencies.

6.1 Medical registration

Panel members must maintain their registration and unconditional good standing with their medical board and professional college (if issued by the relevant authority). Any change to registration status must be reported immediately to HOC. Should a panel member become unregistered in their country of practice they must inform HOC of their retirement from the panel. Panel members are required to provide evidence of their current registration or licence status during an onsite audit visit or at HOC's request.

6.2 Ethical and professional responsibilities of panel members

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

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

6.3 Conflict of interest

Because panel members provide a service on behalf of the Australian Government, it is important to avoid both the fact and the perception of conflict of interest, and that any perceived conflict of interest is fully disclosed.

Therefore when conducting Australian visa health examinations, panel members should:

- perform the duties of his/her practice impartially, uninfluenced by fear or favour
- avoid situations in which their private, financial or other interests, conflict, or might reasonably be thought to conflict with conducting health assessments for Australian visa applicants
- consider whether their commercial and professional relationships with their associated clinics and other third parties, such as migration agencies, present an actual or perceived conflict of interest, and would impact on the independence and reliability of health reports provided by the clinics
- when the interests of members of their immediate family are involved, advise HOC and the visa applicant's case officer of the relationship and potential conflict of interest
- not use information obtained in the course of the health assessment to gain, directly or indirectly, a financial advantage for themselves, or for any other person, and
- not be an applicant's treating doctor. If the applicant does not have a treating doctor and expresses a wish to remain as a patient at the clinic, then the applicant should be referred to another doctor within the clinic. It is acceptable for the second doctor to see the applicant even if they are a panel doctor, as long as they have not participated in the immigration health examination of the applicant.

Panel members should advise HOC of any instances where others may perceive that the panel member has a conflict of interest in performing Australian immigration examinations. Such instances will not automatically lead to removal from the panel.

6.4 Communication

Panel doctors and chief radiologists are required to read and write English. Panel members must ensure all reports are completed in, or translated into, English by an accredited translator or by the panel clinic. Reports should clearly show the visa applicant's name, date of birth and passport number.

Additionally, panel doctors are expected to speak English in order to communicate effectively with departmental staff and visa applicants from English speaking countries.

Panel doctors and chief radiologists are responsible for keeping informed of the latest version of the panel instructions and disseminating HOC communication including newsletters and support documents. HOC anticipates and encourages regular contact with panel members.

6.5 Record keeping

Panel members should keep adequate records of all immigration health examinations which include the applicants' details and recommendation for a period of at least six months. Comprehensive notes should also be kept of any applicant where significant abnormalities or identity concerns are identified during any part of the examination. Clinic records should also include the number of immigration health examinations undertaken, as well as number of cases of HIV and active/inactive TB.

Panel members should ensure that applicant forms and reports are accessible only to authorised clinic staff during the health examination(s). Applicant records must be kept in a secure document or electronic storage system.

6.6 Onsite audit visits and desk audits

Panel members work is reviewed by:

- auditing of health examination reports and x-ray films by MOCs
- onsite audit visits to clinics, and
- the investigation of complaints.

In accepting appointment to the panel, members agree to such audits and reviews, and must be in attendance when onsite audit visits occur.

An onsite audit visit will include the completion of a Clinic Assessment form, an interview with the panel member(s) and introduction to delegated nurses or administrative staff involved in immigration health examinations, and an inspection of the clinic, x-ray facilities, chest clinic and laboratory (if onsite). An audit visit may also incorporate an inspection of associated offsite laboratories and chest clinics. Arrangements for offsite visits will be made prior to or during the onsite audit by a MOC

Please note, the absence of a panel member during onsite audit visits may result in removal from the panel.

7 Continuity of appointment

7.1 Relocation of a panel member's practice

A member is appointed to the panel at a specific clinic location. If a panel member intends to relocate they must inform HOC to seek approval for appointment at the new location. If a panel member relocates and proceeds to conduct medical or radiological examinations without prior authorisation, they may be suspended or removed permanently.

7.2 Retirement and withdrawal of membership

HOC requests four weeks notice if a panel member intends to retire or withdraw their membership of the panel. Panel members intending to retire or withdraw their panel membership may be asked to nominate a successor.

7.3 Suspension from the panel

Where the department has evidence of substantial failure or an accumulation of significant errors, in any part of the health examination, the panel member will be notified in writing. The panel member may be liable to immediate suspension, depending on the seriousness of the issue(s).

Immediate suspension may occur if HOC identifies a threat or risk to the safety of the Australian community's public health, arising from a significant error in reporting, or if a complaint involves serious professional misconduct. In such cases, HOC will provide the panel member with a written notice of suspension advising the panel member of the reasons for the suspension, where it is possible to do so without breaching the applicant's privacy.

Where a panel member is suspended, an investigation will be conducted. The panel member will have an opportunity to respond in writing to a notification of suspension before a final decision is made by HOC as to whether they will remain on the panel.

Although panel members are appointed as individuals, where more than one individual in a practice has been appointed as a panel member, the behaviour of each may reflect on the integrity of the practice itself. HOC may suspend or remove, at its discretion, each of the panel doctors or radiologists in a practice where one person operating from that practice is under investigation.

7.4 Removal from the panel

Panel members may be removed from the panel at the discretion of HOC. The decision to remove a panel member is final and HOC will not enter into a review process.

The number of panel members in a region is determined by the need for immigration health examinations. This need is determined by HOC in consultation with the post. Removal may occur where there is a decreased need for panel members in a region, where technological developments alter local panel requirements, or where a change in policy or regulatory structure takes place. HOC will make reasonable efforts to give as much notice as possible to panel members of any intended changes to panel composition and number.

In cases where a panel member may be liable for removal as a result of clinical concerns, they will be informed of the substance of the issue(s) against them. A response will be sought and given fair consideration prior to a decision being made to remove them from the panel.

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

8 Complaint management

8.1 What to do if an applicant says they want to make a complaint?

First, try to resolve the problem with the applicant directly. Ask them politely what they are concerned about, then:

- listen to what they have to say
- if the applicant is upset about action you are taking, then explain the reasons (such as why you requested an additional test, or why you referred them to a specialist)
- apologise if it is clear that the applicant has received sub-standard service (for example, if a staff member was rude)
- resolve the problem if you are able to
- advise the applicant to contact the local post and HOC if they are still concerned, and
- keep a record of what happened.

In return, you may expect the applicant to:

- treat you with respect
- be polite, and
- listen to your explanation.

If you feel threatened by the applicant, or the applicant is rude:

- try to avoid conflict
- keep calm
- continue to be polite, and
- keep a detailed record of what happened, and inform your local post and HOC immediately.

8.2 What will HOC do if they receive a complaint?

HOC will ask:

- for further information from the complainant
- for the complainant's consent to disclose their personal details to the panel member concerned, and
- the panel member for their recollection of events.

HOC will assess all the information to decide whether the complaint is founded or not.

Panel members must not contact an applicant in regard to a complaint under investigation by HOC without the prior consent of HOC.

HOC will write to the panel member with the outcome of the investigation and will advise the complainant that action has taken place. For privacy reasons, applicants will not be provided with specific details of the action taken.

- If the complaint is unfounded, HOC will take no further action and record the details in the clinic file.
- If the complaint is determined founded but considered minor, HOC will record the details in the clinic file and may contact the panel member if it frequently recurs.
- If the complaint is determined founded and considered significant, HOC will seek the panel member's cooperation in addressing the issue. In some serious instances, HOC may consider suspension or permanent removal of the doctor from the panel.

It is also important for panel members to know that HOC may be approached by third party organisations requesting information about panel members and former panel members in relation to their activities as panel members. Such organisations may include local medical councils and police departments.

The information requested may include the person's updated contact details and any history of complaints made against the panel member or their clinic. Panel members should be aware that HOC usually discloses such information, on request, to the bodies described above and to other statutory or regulatory bodies with an interest in medical professional activities.

8.3 Resolving complaints against panel radiology clinics

A radiology clinic may be suspended or removed from the panel due to an accumulation of substantive reporting failures, or a significant breach in the integrity of the immigration radiological examination process.

In the circumstance where only the chief radiologist is suspended or removed from the panel as a result of a significant reporting error, another panel radiologist can assume the responsibilities of chief radiologist during the suspension period or nominate for appointment. Details of the candidate should be forwarded to HOC.

9 Client services

9.1 Clinic facilities and hygiene

Panel clinics should make reasonable efforts to facilitate access to their premises and promote the applicants comfort. Amenities ought to include:

- a reception or waiting area large enough to accommodate the usual number of applicants and other people waiting
- toilets with hand cleaning facilities located within the clinic itself. Toilets not within the clinic must be adjacent or within very close proximity, and
- where appropriate, heating and/or air conditioning.

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

9.1.1 Medical clinics

A dedicated consultation room or area must be available for the exclusive use of the panel doctor or delegated nurse. It must not be open to the public or shared with other staff during the examination. Each consultation room or area must have:

- adequate lighting
- an examination couch
- appropriate medical equipment for an immigration health examination
- access to a properly maintained specimen fridge (if the pathology laboratory is offsite)
- hand-cleaning facilities readily available
- facilities to protect patient privacy when applicants are required to dress/undress, including use of an adequate curtain or screen, and gown or sheet, and
- preferably, facilities for safe-keeping of applicants' possessions.

9.1.2 Radiology clinics

Radiology suites must have:

- adequate and well-maintained radiology equipment
- appropriate self-protective equipment
- radiation safety guidelines
- abdominal shielding
- facilities to protect patient privacy when applicants are required to dress/undress including use of an adequate curtain or screen, and gown, and
- preferably, facilities for safe-keeping of applicants' possessions.

9.2 Waiting periods

Clients should be able to schedule an appointment within a reasonable timeframe, that is, no more than 10 working days and preferably within a few working days.

9.3 Duration of examination

The medical examination should be thorough and complete, based on taking a history, examining the applicant and completing the form. HOC anticipates the physical 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 30-60 minutes.

9.4 Cultural and language aspects of examinations

Panel doctors should be aware of cultural expectations in relation to medical examinations and history-taking. If applicants do not speak the language of the panel doctor, arrangements are to be made for an interpreter. Costs are the responsibility of the applicant, except in the case of refugees or applicants in detention in Australia. The interpreter should not be a family member or a representing agent due to a potential conflict of interest, and to avoid the risk of misinformation leading to a misdiagnosis. The panel doctor must be satisfied as to the interpreter's impartiality, confidentiality and ability to interpret accurately.

9.5 Privacy considerations

Clinic facilities should protect the privacy and confidentiality of patients. Applicants should be requested to remove sufficient clothing for an x-ray or a full and appropriate medical examination. Applicants must be able to undress and dress in private. Applicants should have access to a changing room or curtained-off area, or be shielded by a privacy screen. A gown or sheet should be offered when the applicant needs to undress for the chest x-ray or physical examination. Female applicants should be asked to remove brassieres only for the purposes of and during breast examination.

9.6 Chaperones

All physical examinations should be conducted in a manner compatible with local standards, good practice and privacy. A parent or guardian must be present when a child is examined or x-rayed. Where the panel doctor, radiographer or panel radiologist is male, a female chaperone must be available and her presence during the x-ray or physical examination offered to all female applicants. Even when a female family member accompanies a female applicant, it is advisable to offer and also have a female member of the clinic staff present.

Aspects of the immigration health examination that may make applicants uncomfortable, such as breast examinations for women 40 or more years of age or where clinically indicated, should be made known to applicants before the examination starts. This advice should ideally be given at the time the appointment is made, or when the applicant arrives at reception.

9.7 Children for adoption

Medical examinations of children for adoption have special requirements, and panel doctors should take care to ensure that the requirements requested by the department are met.

Panel doctors should avoid any conflict of interest (see page 11). Doctors should not conduct immigration health examinations on children from orphanages with which the panel doctor is associated. Any such associations should be declared on an applicant's form 26. Children requiring specialist assessment should not be referred to specialists associated with the orphanage.

9.8 Pregnant women and x-ray examination

All women of reproductive age should be asked about the date of their last menstrual period. Pregnant women should be advised that they have the option of deferring their chest x-ray, and therefore the finalisation of their visa application, until after the birth, or they may undergo the examination with abdominal shielding. The Australian Government does not recommend the taking of chest x-rays during pregnancy. A full explanation of the risks must be provided by the panel doctor or the pregnant woman's treating doctor before she makes a decision as to whether to proceed.

If, after a full explanation of the risks, a pregnant woman elects to undergo a chest x-ray, forms 26 and 160 should be endorsed with appropriate comments. The following guidelines should be followed:

- the film must be full-sized (page 47)
- the field size must be strictly limited to include the chest only (that is, not the abdomen or head)
- the panel doctor and radiographer need to note that consent has been obtained, and
- abdominal shielding must be used.

For applicants who choose to delay the x-ray until after childbirth, reference should be made on form 26 to the presence or absence of any history or clinical evidence of TB and the countries in which the applicant has lived in the past five years.

In exceptional circumstances (for example, for compassionate and compelling reasons), the Australian Government may issue an emergency visa to a pregnant applicant without a radiological examination. Applicants seeking an exemption should contact their case officer.

10 Setting fees for Australian immigration health examinations

Panel members outside Australia are not contracted to, or paid by, the Australian Government for providing immigration health examinations. Panel members are to charge visa applicants directly for examinations undertaken, and it is the responsibility of the applicant to pay the fee.

The Australian Government does not prescribe a fee structure and considers that panel members must be remunerated appropriately. Fees should be consistent with local fees and charges for similar services. Fee structures well above or below local market rates are not acceptable and will be investigated by HOC.

Applicants should be advised of standard examination fees in advance, including mailing/courier costs. Fee schedules should be displayed in the reception area and/or provided to applicants for review prior to their appointment. Standard fees and courier charges should be paid prior to the examination. Fully itemised receipts must be issued for each appointment listing separate charges for an examination, blood test(s), any referral(s) and mailing/courier costs.

11 Integrity of the health examination

Panel members are accountable for the integrity of all facets of the health examination. If a panel doctor delegates any minor part of the examination (height, weight, visual-acuity measurements or urinalysis), these elements must be performed by a nurse for whose work the doctor takes responsibility. Likewise panel radiologists are accountable for the integrity of all facets of the examination. If a panel radiologist delegates any minor part of the examination, these elements must be performed by a qualified radiographer for whose work the doctor takes responsibility.

11.1 'Panel doctor shopping'

Panel members must be vigilant that applicants have not been examined elsewhere and are seeking a more favourable result. If a panel member learns during an examination that an applicant has been examined by another panel doctor and/or panel radiologist recently, the nearest post and HOC must be informed by telephone or email immediately.

11.2 Confirming the identity of applicants

Panel members must ascertain that the person who presents for an immigration examination is the actual applicant. Panel members must also ensure that the appropriate identity-control mechanisms are in place at all specialists to whom the applicant is referred, as well as TB testing laboratories and treatment programs.

Panel members and radiographers must:

- confirm the identity of the applicant by sighting the applicant's original passport (see below for acceptable alternative identity documents and processes) and verifying that the photograph attached to forms 26/160 matches the photograph in the passport and the appearance of the person attending for the tests. Passport photographs should be in colour
- confirm the biographical details included in part A of forms 26/160 with the details available in the passport or identity document
- staple (or firmly attach by other means) the photograph to forms 26/160
- certify in writing across the top of the photograph and forms 26/160, without obliterating the image (writing over the seal, if present), that the photograph is a true likeness of the examinee
- request applicants to sign and date the declaration in their presence. If the form has been signed already the applicant should be asked to sign and date the form again, above the first signature, and
- compare the applicant's signature on the passport or identity document, where a signature is present, with their signature on forms 26/160.

A parent or guardian should sign on behalf of an applicant who is under 16 years of age or who is an 'incapable person'. An 'incapable person' is defined as one 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.

11.3 What identification documents are acceptable?

Valid passports are the form of identity that should be requested in all situations, however, in the following exceptional circumstances, alternative documents will be accepted where:

- a passport will not be issued without a visa pre-grant letter
- the applicant is unable to obtain a passport without a visa
- the applicant's passport is at a DIAC office or another post, including the post of another country for processing
- the applicant's passport is with the United Nations High Commissioner for Refugees (UNHCR) or the International Organization for Migration (IOM) for processing in relation to a refugee application or application for another visa for Australia, or
- the applicant is unable to obtain a passport as a result of political or other circumstances in their country of origin.

11.4 Alternative identity procedures

There may be some circumstances in which the passport has been retained by the post or by DIAC's contracted service provider. In these cases panel members should confirm the identity based on:

- a letter or document issued by the post confirming the requirement for a health examination and an alternative identity document (where it is able to be used) or a colour copy of the passport certified by the post or service provider. Note: the photographic image on the copy of the passport must be clearly recognisable to be used to match with the applicant
- the applicant's photographs affixed to the health examination forms by the post or service provider at the time of application together with the completed bio-data section. These photographs must be endorsed by stamp or signature, without obliterating the image, by the post or service provider, after confirming the applicant-provided photographs and the passport are a true likeness.

In both of these cases, DIAC or DIAC's contracted representative has sighted the original passport and made an endorsement of a copy or photograph provided.

DIAC's contracted service providers DO NOT include migration agents or in-country education agents.

11.5 Non-migrating dependants

Sometimes, panel members will be asked to examine a visa applicants dependants, who themselves are not part of a visa application. These non-migrating dependants may not hold a passport but the panel member must nevertheless satisfy themselves as to the identity of the dependant. This can be done by comparing the information in a suite of identity documents including but not solely limited to the following: birth certificate, government health care cards, national identity cards or school registration documents and should include photographic identification.

11.6 National identity cards

National identity cards are not acceptable as the sole and primary identity document without adherence to the above alternative identity procedures. Outside of this procedure, original passports must be used.

In cases where national identity cards are used, only new and original national identity cards, incorporating a current photograph, full name, date of birth and signature, can be submitted—photocopies are not acceptable. The national identity card must have been issued within the last 10 years. A signed photocopy of the national identity card, certified by the panel member, must be attached to forms 26/160, as well as a note made on the photocopy of the reasons for its use.

For China, only new identity cards that were introduced in 2004 are acceptable.

Not all national identity cards can be accepted. National identity cards from the following countries are not acceptable forms of identification due to inadequate security features:

- Afghanistan
- Cambodia
- Indonesia
- Republic of South Africa, and
- Taiwan.

For these locations and for locations where a national identity card is not available, a valid original passport is the only acceptable form of identification.

Online Health (eHealth): For all eVisa cases, and all Online Health examinations, applicants must use an original passport for identifcation.

11.7 Driver licences and other documents

Driver licences, student cards or similar identity documents by themselves are not acceptable as the sole or primary document for identity verification. Driver licences are a document permitting the holder to drive and often contain little integrity in terms of the holder's identity. They can be used only as one of a 'suite of identity documents' for the identification of non-migrating dependants.

11.8 Absence of appropriate identity documents

In the absence of appropriate identity documents, health examinations should proceed, and forms 26/160 should be annotated to reflect this. DIAC will follow-up this issue with the applicant. The applicant may be required to return to your clinic and complete a further identification check.

Please contact HOC if you have any queries or feedback about identity issues. We appreciate your assistance in ensuring the integrity of visa health examinations.

11.9 Doubts about identity of examinee

Should a panel member have doubts about the identity of an examinee, the examination and report should be completed as usual. Do not confront the applicant.

The panel member must provide details of the reasons for their suspicions on forms 26/160. Please include photocopies of any identification documents provided by the applicant. Online Health (ehealth) clinics must attach a scanned copy of the client's passport to their health case when they raise an identity concern fag.

If there are any issues with identification of applicants please immediately contact HOC or the nearest post for advice.

12 Specimen integrity

Panel doctors should perform specimen collection onsite. If the panel doctor delegates this procedure to a nurse or phlebotomist, the panel doctor remains accountable for the integrity of this part of the examination. Correct specimen collection will entail:

- confirming the identity of the applicant by sighting the applicant's original passport, and verifying that the photograph attached to form 26 matches the photograph in the passport and the appearance of the person attending for the tests at every examination point
- explaining the collection procedure to applicants
- using appropriate disposable equipment or sterilisation
- safe storage and disposal of clinical waste including sharps
- disinfecting the area of skin for venepuncture
- urine collection in a secure setting within the clinic or very close proximity of the clinic
- urine dipstick testing onsite
- accurate specimen identification using non-removable labels
- incorporating appropriate security or coding procedures into the testing process for specimens and laboratory requests
- ensuring all pathology test kits are within expiration dates
- refrigeration of specimens or transportation to the laboratory within one hour
- maintaining specimen integrity during storage
- where necessary, ensuring secure transportation (including the container) with a laboratory request for specimens. Specimens must never be given to applicants for transport, and
- participation in external quality-assurance programs.

13 Disclosure of abnormal health conditions to applicants

13.1 If a medical condition is detected

In all cases, the panel member must advise the applicant of any abnormal findings. There may also be some circumstances where it is preferable to notify the applicant's treating doctor. It is not appropriate for the panel member to undertake any form of treatment in relation to the applicant. A panel member must not enter into a therapeutic relationship with the applicant. The panel member's role is that of an independent examiner who is to provide the department with an impartial opinion.

13.2 Duty of care

If the panel member finds the applicant to be seriously ill and in need of urgent treatment, the panel member must inform the applicant and refer them to his or her usual doctor, or to an appropriate specialist or health facility. Any specialist, health facility or doctor to whom the applicant has been referred to, should be recorded on forms 26/160. Panel members should record any counselling and referral action undertaken in relation to serious medical conditions.

14 Further tests and specialist referrals

Panel doctors or panel radiologists may directly refer applicants to specialists. Panel members are required to explain to clients why a further test, or a referral to a specialist, is required. Panel members should also explain that the results will be sent directly from the specialist to the panel member, who will then forward the reports to the department.

Panel members will use clinical judgment in the course of an immigration examination to determine the need for referral to a specialist. In cases where invasive procedures are required, or the additional tests will be expensive, panel members should discuss with the applicant the option of waiting for a MOC opinion. If applicants prefer not to undergo specialist evaluation at the request of the panel doctor, forms 26/160 should be annotated accordingly and graded B. The applicant may wait for a request to be made by a MOC.

In general, the choice of a specialist is not limited. However, in some countries and for some conditions (for example, suspected TB), HOC or the post may hold a list of names of approved specialists or chest clinics from which they may request that a particular specialist or chest clinic be used. When difficulties are experienced in the choice of a suitable specialist, panel doctors should consult HOC.

Panel members should advise the specialist to:

- confirm the identity of the applicant by sighting the applicant's original passport and identifying that the photograph in the passport and the appearance of the person attending for examination or testing are the same
- provide detailed reports (in English, if possible) including results of all necessary investigations, a description of the recommended management and likely prognosis of the condition, and
- send their reports directly to the panel member in a sealed envelope. A copy of the report may be provided to the applicant by the panel member.

Specialists are not responsible for providing opinions whether applicants meet the health criteria. This is the responsibility of a MOC.

14.1 Forwarding specialist reports

Original specialist reports are to be sent directly to the panel member, who should then forward these to the appropriate processing office with forms 26/160. The reports should be written in or translated into English by an accredited translator or by the panel member themselves. Specialist reports should clearly show the visa applicant's name, date of birth and passport number.

15 Recommendations

When an abnormality is detected or declared, panel members must provide sufficient detail on the nature, severity and possible prognosis of the medical condition, so that the MOC is able to clearly appreciate the applicant's state of health and the relative significance of the medical condition. Comment on how each medical condition currently affects, or is likely to affect, the applicant's normal daily functioning, level of independence and fitness for work. At the completion of the examination, panel doctors are asked to provide an A' or 'B' grading. Guidelines on how to determine the grading are on page 44 and 49.

16 Where to send completed forms

Panel members must never give the original forms, films, reports or specimens back to an applicant or their representative during the health examination(s) to send to the department.

When an applicant completes the form and gives it to a panel clinic, the information becomes the property of the Commonwealth of Australia. The original forms 26/160, test results, reports and x-ray films must be sent directly to the processing office from the panel clinic.

Upon request, panel members can provide an applicant with copies of any forms, diagnostic reports or test results without permission from the department.

16.1 Panel doctors

Panel doctors should record and staple pathology test results to form 26 and attach any specialist reports. The form 26, and the form 160 with x-ray film if the applicant has undergone a radiological examination, must be placed into a sealed envelope and returned directly to the appropriate processing office.

16.2 Panel radiologists

If the applicant has been requested to undergo both a medical and radiological examination, radiologists should send form 160 directly to the examining doctor in a sealed envelope so that they, in turn, can provide a comprehensive report on the visa applicant. Otherwise, radiologists must forward form 160 with x-ray film directly to the appropriate processing office in a sealed envelope. Films should be dry before they are handled and must not be folded or rolled at any stage. They must be kept fat and protected by cardboard when prepared for dispatch. Radiology clinics should never staple documents or reports to x-ray films.

16.3 Forwarding the health results

Documents must be forwarded to the processing office by courier or registered mail. Any costs associated with mailing or couriering the reports to DIAC may be charged to applicants. Applicants should be advised of the potential courier or mailing costs when they schedule an appointment. As they have paid for this service, applicants should also be provided with the registered mail or courier tracking number that relates to their documents.

When sending documents by courier to Australia, panel members will be asked to record the commercial value of the contents of the package. Immigration medical documentation does not have a commercial value, so the commercial value should be noted as ‘Nil’.

Panel member reports must not be sent Cash On Delivery. Any costs incurred by receiving offices may be invoiced to the panel member.

17 Incomplete health examination results

If an applicant:

- indicates that they are withdrawing from the application process
- does not proceed with the health examination due to medical conditions which they feel will make them unlikely to meet the health criteria
- has not returned to complete the health or radiological examination and has not made contact with the doctor, radiologist or clinic within two weeks, or
- has not supplied the requested information within two weeks of an examination and the doctor or radiologist has not been informed of credible difficulties in obtaining the report

the panel member must:

- complete forms 26/160 to cover what has been completed to date
- state the reason for not completing the medicals (if known)
- make a B recommendation
- clearly mark the front of the form as 'Incomplete medical examination', and
- send all the partially completed work back to the nearest post for forwarding to HOC, or send directly to HOC if the completed medical would have been sent to HOC and courier fees have been paid by the applicant. By ensuring applicants pay courier costs up-front, panel members avoid courier costs for incomplete medicals.

Forms should not be retained indefinitely whilst waiting for applicants to send new information or to complete tests, even if the forms are awaiting identity verification.

Due to the fast turnaround time of Online Health (eHealth) applications, if an applicant does not continue with their Online Health examination, please inform HOC within two days.

18 Other panel doctor roles

18.1 Immunisation

Rubella vaccinations are strongly encouraged for women of child-bearing age.

Parents are strongly encouraged to have their children immunised against hepatitis B, diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, haemophilus infuenzae type-b (Hib), pneumococcal and meningococcal infections, mumps, measles, rubella and varicella (chickenpox). It is also encouraged that babies between the ages of 2 and 8 months of age are immunised against rotavirus.

18.1.1 Records of immunisation

Panel doctors are asked to counsel applicants so that outstanding immunisations from the above list are received before travelling to Australia. Applicants should be reminded to bring with them any records they have or can obtain concerning their immunisations.

Parents should be advised to take any immunisation records for their children to Australia.

18.2 Yellow fever

Please alert the applicant to Australia's entry requirements for yellow fever. Advise applicants that all people over one year of age who have stayed overnight or longer in a declared yellow fever infected country within six days before arriving in Australia are required to hold an international yellow fever vaccination certificate. Ask applicants if they have been vaccinated against yellow fever and hold an international yellow fever vaccination certificate. Explain that they will be required to present the certificate on arrival in Australia. In instances where vaccination is medically contraindicated, applicants should be advised that they would not be refused entry. Rather, on entering Australia, they would be placed under quarantine surveillance. Quarantine surveillance for yellow fever lasts for up to one week.

Further information on Australia's requirements for yellow fever vaccination, including the list of yellow fever declared places, can be found at the Department of Health's website (www.health.gov.au) by typing 'yellow fever' into the search facility.

18.3 DNA testing counselling guidelines

The guidelines below assist panel doctors when counselling applicants who undertake genetic (DNA) testing for the purposes of verifying claimed family relationships.

18.3.1 Pre-test counselling

Before DNA testing is performed, pre-test counselling should be provided to the donor by the panel doctor collecting the sample. The doctor should explain:

- that undergoing DNA testing is voluntary for the donor
- the process of collecting samples
- that the test is used to determine biological relationships, that the results of the test will be accurate and reliable in determining biological links between the donors and are considered conclusive in parentage-testing cases, and
- counselling options for applicants/sponsors should results show unexpected biological results.

18.3.2 Post-test counselling

If the results of an applicant's/sponsor's DNA test show unexpected biological results (for example, a parentage test rules out a 'parent' donor), the applicant/sponsor may wish to receive counselling. The panel doctor should refer the applicant/sponsor 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.

18.4 Predeparture Medical Screening (PDMS)

DIAC offers Predeparture Medical Screening (PDMS) to Refugee and Special Humanitarian Program (RSHP) visa holders. The purpose of PDMS is to ensure that RSHP clients are 'ft to fly' to Australia, to test for communicable diseases, and to facilitate onshore health care for RSHP clients.

PDMS is currently operational in Africa, Asia and the Middle East. Depending on the composition of the RSHP in coming years, PDMS may also be expanded to additional locations.

The conduct of PDMS is governed by the PDMS protocols and PDMS guidelines which are available on request from posts located in PDMS regions. The protocols specify that PDMS must be carried out by DIAC panel doctors.

The PDMS process differs operationally from region to region, however, as a general rule, panel doctors will be notified by either the local DIAC post or IOM in order to arrange PDMS appointments for departing RSHP clients.

There are two forms of PDMS: (i) full PDMS and (ii) PDMS 'short', each requiring a different set of medical screening and treatment procedures. Full PDMS services require panel doctors to:

- conduct a thorough physical examination
- perform rapid diagnostic testing for malaria
- empirically treat parasites and infestations
- evaluate known cases of tuberculosis
- administer immunisation against measles, mumps and rubella (MMR)
- perform any additional screening/treatment deemed necessary.

Where PDMS 'short' is operational, panel doctors are required to:

- take and record client's temperature
- conduct a brief physical examination
- check for gastrointestinal symptoms
- evaluate health aspects of the client's previous environment/camp.

Panel doctors are required to outline the result of PDMS on special templates provided, and to forward these to DIAC. Panel doctors are also asked to provide a package of health documents, summarising health results, to clients for them to carry with them to Australia.

In performing the above screening/treatment, panel doctors are asked to make a judgment on whether clients are fit to fly. In cases where clients are deemed unfit to fly, panel doctors must inform DIAC without delay, and arrange for any necessary treatment that would lead to the client becoming fit to fly.

Panel doctors are also asked to make an assessment on whether clients, although ft to fly, require a medical escort to medically assist them during fight and/or would require immediate medical follow-up once in Australia.

Panel doctors are required to liaise with MOCs in making decisions on client delays, or the need for medical escorts.

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Part B: For panel doctors

The following instructions relate to the questions on the form 26.

Form 26

19 Applicant's medical history

Panel doctors must review parts A and B, questions 1-28 of form 26, taking note of any relevant medical history. If the applicant has completed the questions before seeing the doctor, the doctor should confirm the answers with the applicant.

These questions are designed to assist the examining doctor to assess aspects of the applicant's health of particular relevance and importance to the Australian Government's health requirements. Nevertheless, the questions do not replace the need for doctors to obtain comprehensive histories themselves. If there is no medical history recorded, a panel doctor should verify with an applicant that this is indeed the case.

20 Question 1: Height and weight

The applicant's height and weight should be determined accurately and recorded in centimetres and kilograms respectively.

In infants and children, height and weight should be assessed against standardised height and weight charts for the appropriate population. A comment should always be included as to whether the child's height and weight are standard for age and compatible with normal development.

Children who are significantly underweight for age (under 3rd centile) must be referred to a specialist paediatrician for assessment as to the cause. If developmental delay is suspected, the assessment should include appropriate psychological testing, and developmental age/IQ estimation. Growth charts can be accessed through:

- Centre for Adoption Medicine: www.adoptmed.org/topics/growth-charts.html

In adults, Body Mass Index (BMI) is calculated by the formula: weight (kg)/height $(m)^2$. A BMI > 30 is considered obese. BMI calculators can be accessed through:

- Centres for Disease Control (US): www.cdc.gov/nccdphp/dnpa/growthcharts/bmi_tools.htm

20.1 Overweight

B-graded applicants with known or suspected complications of obesity should be referred to a specialist physician for further assessment. Complications may include hypertension, joint disease, cardiac disease and diabetes. The specialist's assessment should address physical examination findings, the nature and severity of complications, general mobility, need for surgery, level of independence and expected prognosis.

Refer to Attachment 4 'BMI' for required investigations and grading of obesity.

20.2 Underweight

Applicants with a BMI < 16 kg/m^2 with a history of recent unexplained weight loss must be referred to an appropriate specialist for assessment of possible cause.

Refer to Attachment 4 'BMI' for required investigations and grading of underweight applicants.

21 Question 2: Eyes

Assessment should include clinical examination of the eye and measurement of visual acuity. The distance visual acuity of each eye should be tested separately, with corrective lenses if worn, by means of Snellen's or a similar test and the results recorded in metric fractions. For illiterate applicants, E charts can be used.

If defective vision is found, record the cause (if known), for example, myopia, hypermetropia or astigmatism. If an applicant has forgotten to bring glasses, pinhole testing for acuity should be used. In children too young to read the test charts or to use an E-chart or a picture chart, a comment must be made on whether the vision appears normal.

Refer to Attachment 4 for required investigations and grading of visual impairment.

22 Question 3: Urinalysis

- Dipstick testing only is required.
- Every applicant 5 or more years of age who is undertaking a health examination must have their urine tested for the presence of albumin, sugar and blood.
- Children under 5 years of age should be tested if indicated, for example, when there is a history of kidney disease or recent tonsillitis.
- Urine should be passed at the time and place of the examination in the panel doctor's rooms (not in the laboratory) and while the applicant is under observation.
- To maintain the integrity of the test, we recommend that the applicant is escorted and supervised during their access to the toilet, and that a blue toilet dye is used. Appropriately minimise the applicant's clothing and provide gowns, restricting access to personal items such as handbags.
- Please immediately check for 'freshness' of the specimen (37ºC, bubbles, condensation on the jar).

22.1 Recording urinalysis results on form 26

Urinalysis results should be recorded on form 26 as negative or quantitatively, as trace, small, moderate, large, or by appropriate plus signs, for example, '+'.

22.1.1 Repeat testing

If a trace or more of protein, blood or glucose is detected, the urine dipstick test should be repeated immediately on a new specimen, except in women where an abnormality occurs due to menstruation. Please repeat and record urinalysis following completion of menstruation.

If the test is still positive, obtain and attach results of urine microscopy culture and sensitivity, serum creatinine or glucose tests as indicated. Please do not record additional dipstick results, for example, white cells or ketones. Any additional pathology reports relating to urine testing should be attached and the results entered on form 26.

22.1.2 Haematuria

For young people, isolated haematuria is usually insignificant from a health requirement perspective.

The major abnormality to detect is cancer. Therefore if the applicant is:

- 50 or more years of age *and*
- has greater than 10 red blood cells per high power field

assessment and investigation by a urologist should be requested.

If there are other abnormalities, or clinical suspicion of other disease processes, these need to be taken into account. The case should be graded B.

22.1.3 Proteinuria

Please observe the following for cases where there is 'one plus' or more of protein on repeat urine testing (which in all cases will be a B grading):

- For temporary visas < 12 months stay (for example, visa 676 or working holiday makers), serum creatinine is required. If creatinine > 2.0 mg/dL (177 µmol/L), refer to a nephrologist for investigation.
- For temporary visas > 12 months (for example, 457, students), serum creatinine and urine protein/ creatinine ratio is required (estimation of urinary protein). If creatinine > 1.5 mg/dL (133 µmol/L), refer to a nephrologist for investigation.
- For permanent visas, serum creatinine and urine protein/creatinine ratio are required. If the results are abnormal, the applicant should be referred to a nephrologist for investigation. If there is concomitant untreated hypertension or diabetes, then also refer the applicant to an appropriate specialist for treatment.

23 Question 4: Cardiovascular disease

Refer to Attachment 4 for required investigations and grading of cardiac murmur, hypertension, and ischaemic heart disease.

For all other cardiac conditions, form 26 should be graded B.

- If the cardiac condition is stable, asymptomatic, uncomplicated and considered unlikely to impact the applicant's stay in Australia, no further action is required.
- If the cardiac condition is unstable or progressive, symptomatic, complicated or likely to impact the applicant's health during the proposed stay, referral to a cardiologist or appropriate specialist is required. The cardiologist's assessment should address history, diagnosis, clinical examination findings, treatment needs and expected prognosis. The report should be attached to form 26 for submission.

24 Question 5: Respiratory system

Cases of active tuberculosis (TB), contact with TB or suspicion of TB should be graded B.

24.1 Pulmonary tuberculosis

Information on TB can be accessed through the:

- Centres for Disease Control and Prevention, Division of Tuberculosis Elimination: www.cdc.gov/tb/default.htm

The health examination places particular emphasis on excluding a history of TB (including haemoptysis) or contact with TB. The maintenance of a very high index of suspicion of TB is vital to its diagnosis.

If a history of TB is elicited, full treatment records should be obtained.

All applicants 11 or more years of age must undergo a chest x-ray examination. Applicants under 11 years of age, who are suspected of having TB or have a history of contact with a case of known TB, must also undergo a chest x-ray examination.

Usually, further films with alternative views are necessary to determine the nature of an abnormality. Old chest films should be obtained if possible, as comparison with old films will help in this determination. It is very important that other conditions that may mimic TB be excluded (for example, lung cancer).

Panel doctors should proceed to bacteriological examination as follows:

24.2 Sputum collection

- obtain sputum specimens of 5-10 ml
- early-morning specimens are preferable
- three specimens are required at least 24 hours apart, preferably on consecutive days
- sputum must be collected directly in an appropriate area in the panel doctor's clinic or at the laboratory and should be observed directly, and
- salivary specimens are unacceptable. The collection of a true sputum specimen is of critical importance if the organism is to be isolated.

24.3 Transport of sputum specimens:

Samples should be securely and promptly transported to the laboratory promptly. Applicants should not be asked to transport specimens to the laboratory. If not transported within one hour, samples should be refrigerated (but not frozen). When received by the laboratory, specimens ideally should be processed within 24 hours of receipt.

24.4 TB alerts

If there are strong clinical suspicions of active TB, particularly:

- smear positive sputum
- fever
- cough
- night sweats
- weight loss, and
- an abnormal x-ray

the panel member must, within 48 hours of the examination, notify HOC by email or fax of this finding, pending further results.

Details required for notification of an active TB case are:

- family name
- given names
- date of birth (dd/mm/yyyy)
- passport number
- country of citizenship
- visa subclass number
- office where the application lodged (if known), and
- a brief description of the symptoms.

Panel doctors should notify HOC even if the applicant indicates that they are withdrawing from the process. Acknowledging the applicant's privacy, this information must be marked 'Medical in Confidence' and only be referred to HOC via:

- the website: www.immi.gov.au/gateways/panel_doctors
- email: Health.Operations.Centre@immi.gov.au, or
- fax: +61 2 8666 5900 / 5901

24.5 Duration of culture and reporting times

- Specimens reported as giving negative results should be cultured for a minimum of 6 weeks, with a final report produced within 8 weeks of specimen receipt.
- Laboratory cultures on solid media or by means of BACTEC™ are acceptable. With appropriate quality-assurance and quality-control methods, BACTEC™ can identify positive cultures with a median time of 11-18 days. BACTEC™ cultures should be kept for up to 6 weeks before being reported as negative.
- Drug sensitivity testing is to be carried out on all positive TB cultures. Results are to be provided with the chest specialist's report.

24.6 Treatment

The need for chemotherapy in any particular case will be decided by the treating doctor in consultation with the applicant. If treatment is undertaken, it must be monitored closely by the specialist. Inadequate chemotherapy is the major cause of drug-resistant organisms.

In cases of active disease, evidence of the satisfactory completion of a current course of supervised treatment is required before a medical clearance can be given by a MOC. Demonstrated radiological stability of lesions over a period of at least six months is an acceptable alternative in most persons without an adequate history of previous treatment, who have negative results of sputum cultures.

The standard treatment protocol recommended in the Therapeutic Guidelines: Antibiotic (Version 13, 2006) is either a daily regimen of:

- Ethambutol
- Isoniazid
- Rifampicin
- Pyrazinamide

or an intermittent, fully supervised regimen, until bacterial cultures give negative results and a course of at least six months of chemotherapy (pyrazinamide and ethambutol usually are ceased after the first 2 months) has been administered. A certificate from a reputable chest physician, chest clinic or hospital is required as proof of treatment. This certificate must provide details of generic names of drugs used, dosage and frequency of administration, and treatment duration.

24.7 Inactive tuberculosis

Inactive (or latent) TB is asymptomatic infection of healthy persons with incidental signs of past TB exposure (e.g. x-ray scarring, or positive Mantoux) and/or a history of previous TB treatment. If the applicant is asymptomatic, HIV-negative and without radiological signs of active TB, form 26 should be graded B and submitted to the relevant post.

The MOC may request further information if concerned about disease activity. However in most cases the applicant will be cleared for travel, possibly with a Health Undertaking (which requires attendance at a chest clinic in Australia for surveillance). This surveillance is necessary due to the significant («10%) chance of relapse in untreated persons with inactive TB. Relapse also occurs in treated persons but at a much lower rate.

Any symptomatic and/or HIV-positive applicant with signs of TB should be assumed to have active disease until proven otherwise. The case should be graded B.

If you believe HOC has requested sputum collection in an asymptomatic applicant without suspicious x-ray features, and in whom collection of sputum may be of low value or warrant invasive procedures, please send an email and advise whether serial x-rays may present a better option in this case.

24.8 Other respiratory conditions

Applicants with examination findings or x-ray changes indicative of other respiratory disorders, for example, cancer, emphysema, bronchiectasis, must be referred for specialist assessment, which may include CT scan, lung function testing, or biopsy. A definitive diagnosis should be obtained wherever possible. Specialist reports must be forwarded, and form 26 graded B.

25 Question 6: Nervous system

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 loss of time from work must be documented. Specialist referral may be necessary to reach a formal diagnosis and prognosis.

26 Question 7: Mental state

Mental health conditions can be at times particularly difficult to identify. When there is a recent history or current clinical evidence of:

- schizophrenia
- bipolar or depressive affective psychosis
- personality disorder
- paranoid disorder
- autism
- chronic alcohol abuse
- drug dependence or substance abuse
- eating disorders
- chronic neurosis (for example, chronic anxiety or depression, obsessive compulsive disorder, phobias)

referral for psychiatric assessment and determination of prognosis, treatment required, work history, ability to undertake activities of daily living, and social history is necessary.

26.1 Dementia

If dementia is suspected in applicants 70 or more years of age, a MiniMental state examination must be conducted with the protocol (as adapted from Folstein) in Attachment 1. The protocol should be adapted, as appropriate, linguistically and culturally. The score must be entered on form 26 or the Aged Visitor Health Check form. Please note that the test questions should be performed in the applicant's own language or with the assistance of a professional interpreter. If a language barrier to assessment is present, this should be recorded. The Folstein test is a screening tool. If it suggests a problem, a psychiatrist's or geriatrician's opinion should be sought. These cases should be graded B.

27 Question 8: Intelligence

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

The purpose is to determine:

- behaviour
- need for long-term supported or special education
- level of independence and need for assistance, and
- employability.

28 Question 9: Developmental milestones

Developmental assessment of children and young infants should always be undertaken. Developmental milestones (see Attachment 2) should be noted whenever available. With children for adoption, some delay in achieving milestones may be expected where children have been deprived of adequate stimuli.

The following represent critically delayed milestones and must be reported on form 26. These cases should be graded B:

- cannot hold head up unsupported at 8 or more months of age (normal, 4 months)
- cannot sit unsupported at 9 months (normal, 8 months)
- cannot walk at 18 months (normal, 13 months)
- no words by 18 months (normal, 15 months)
- no 2-3 word phrases by 24 months and 36 months respectively (normal, 21 months and 36 months respectively);
- Moro reflex persisting at 6 or more months of age.

Non-symmetrical findings on examination and significant hypotonia or hypertonia are abnormal at any age. These cases should be graded B and referred to a paediatrician or developmental psychologist for further assessment.

29 Question 10: Gastrointestinal system

Operative scars, ileostomy or colostomy sites, hepatosplenomegaly, hernias and any abdominal masses should be documented. Abdominal masses will require further investigation and a report from a specialist. Such a report may include non-invasive investigations, for example, ultrasonography, computed-tomographic or magnetic-resonance imaging. Non-invasive investigations performed in isolation, without a specialist report, are not acceptable.

30 Question 11: Spine and limbs

Taking into consideration the age of the applicant, comment on any abnormalities detected as follows:

30.1 Children

- Likely need for further operations and specialist care
- Effect on future employment
- Need for continuing care

30.2 Working age applicants

- Effect on current and future employment

30.3 Elderly applicants

- Capacity to undertake the activities of daily living and live independently
- Need for joint replacement in the near future

31 Question 12: Skin and lymph nodes

The presence of operative scars must be correlated with the history. The area of skin affected by atopic or other conditions should be documented.

Enlargement of lymph nodes should be described fully and correlated with regional conditions. If there is clinical concern, referral to a haematologist, oncologist or infectious disease specialist for assessment and a report is necessary.

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

Gynaecological examination (vaginal or pelvic examination) is not required. If there has been a history of gynaecological disease, or the panel doctor suspects it, refer the applicant to a gynaecologist. Grade the case B and include copies of any investigations and specialist reports when submitting the case.

32 Question 13: Evidence of drug-taking

Details should be recorded of any indications of possible drug abuse, such as puncture marks, phlebitis, pupil size and mental state. If drug abuse is suspected, the applicant must be referred to a psychiatrist for assessment and management. Full details of diagnosis, management needs, prognosis and ability to work must be included in the specialist report. The case should be graded B.

33 Question 14: Breast examination

Breast examination is not routinely required in women under the age of 40. Breast examination should be offered to all women over the age of 40.

Breast examination should be conducted if there is a history of breast cancer or breast lumps, or axillary nodes are palpated. Applicants should be asked to remove brassieres only for the purposes of and during breast examination. Such examination must be conducted with sensitivity and, in the case of a male doctor, in the presence of a chaperone. If an applicant declines, is unduly anxious or upset about a breast examination, please do not insist. Note the clinical indication(s), if any, and the applicant’s unwillingness on form 26.

Additionally, in countries where breast examinations are not routine, a panel doctor or clinic staff member should advise adult female applicants when they schedule their appointment, or at reception, that a breast examination may be required if clinically indicated.

If there is a risk based on the family medical history, or if otherwise clinically indicated, the case should be graded B.

34 Question 15: Endocrine system

Applicants with glycosuria, or who are known to have diabetes mellitus, should be graded as per Attachment 4.

If there is no evidence of end-organ complications, no further investigation is required. However, if complications are known or suspected, referral to a physician is required for:

- treatment
- assessment of end-organ damage, and
- estimation of prognosis.

Signs of end-organ complications include:

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

Examination of the endocrine system should include thyroid examination. If thyroid disease is detected specialist assessment is required including thyroid function tests and ultrasound. Please exclude malignancy. Benign thyroid disorders can be graded A.

35 Question 16: Ear/nose/throat/mouth

Comment should be made on any significant abnormalities.

36 Question 17: Hearing

If an applicant can hear the panel doctor's questions without difficulty during the examination and can conduct a conversation in response to the panel doctor, then the hearing should be considered satisfactory.

If there is a hearing impairment, the communication skills that are used by the applicant need to be assessed, that is, lip-reading, signing, reading or writing. All hearing impaired applicants require formal audiological assessment, as well as a report from a specialist that details their abilities and special needs, for example, speech therapy, hearing-aids and surgery. If the applicant has a cochlear implant, it should be documented whether age-appropriate pneumococcal and meningococcal vaccinations have been administered and the dates of administration recorded.

37 Question 18: Conditions that would prevent an applicant being employed 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 on form 26. The 'Activities of Daily Living Assessment' (Attachment 3) should be completed for any applicant where there is concern about their ability to undertake the activities of daily living, including the frail elderly. Where there is concern regarding 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. In either case, full details must be provided of any required rehabilitation services currently being provided to the applicant, or which will be required in the future.

38 Question 19: Chest x-ray result

Panel doctors must review form 160, the chest x-ray, and any written report from the panel radiologist for consistency, and compare the results submitted with their own clinical opinion. Any differences of opinion must be recorded on form 26.

39 Question 20: Human immunodeficiency virus (HIV) testing

Doctors should undertake venepuncture. If another person performs venepuncture, the doctor must assume accountability for the security of the process.

Type of applicant	Test for HIV?
Permanent visa applicants 15 or more years of age	Yes
Children for adoption Children who have been, or are to be, adopted by Australian residents. Children for adoption under 2 years of age from sub-Saharan Africa are required to undergo two HIV tests, 3 months apart.	Yes
Unaccompanied minor refugee children	Yes
Children under 15 years of age suspected of infection Children under 15 years of age must be tested if there is a reason to suspect HIV infection on clinical grounds, a history of blood transfusions or haemophilia, or if the mother or father is HIV-seropositive.	Yes
Temporary entry applicants with signs of AIDS present	Yes
Students from Africa 15 or more years of age coming to Australia for 12 months or more (those applying at certain posts in Africa—see table below) including accompanying dependants or immediate family members.	Yes
Hospital and healthcare workers All temporary visa applicants intending to work as, or study to be a doctor, nurse, paramedic or dentist.	Yes

39.1 HIV testing for students from Africa—applicable posts and countries

All student visa applicants who are 15 or more years of age and seeking a stay of more than 12 months, and have lodged their applications at the following African posts are required to undergo an HIV test.

Post	Applications from
Cairo (DIAC)	Sudan
Harare (DFAT)	Botswana, Mozambique, Zimbabwe
Lagos (DFAT)	Benin, Burkina Faso, Cameroon, Cape Verde, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, The Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome & Principe, Senegal, Sierra Leone and Togo
Nairobi (DIAC)	Burundi, Democratic Republic of Congo, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Somalia, Tanzania, Uganda, Zaire
Pretoria (DIAC)	Angola, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia
Other posts	Other posts handling student applications from the above countries are not required to ask for HIV testing. However, they may request an HIV test if, in discussion with a MOC, there is any indication that the test is warranted.

39.2 Acceptable screening tests for HIV

There are four broad categories of HIV tests: simple/rapid anti-HIV tests, enzyme immunoassays (EIAs), immunoblot tests and nucleic-acid tests. HIV screening tests must be taken from the following lists. Any alternatives to these tests should be discussed with HOC before use.

39.2.1 List one: Simple and/or rapid assays

- Capillus HIV/HIV-2 (Cambridge/Trinity Biotech plc)
- Serodia HIV-1/2 (Fujirebio)
- Immunocomb II Bispot HIV-1&2 (Orgenics Ltd)
- Dipstick HIV 1&2 (Pacific Biotech Co. Ltd)
- Determine TM HIV-1/2 (Abbott)
- HIV 1&2 Doublecheck (Orgenics Ltd), or
- Multispot HIV-1/HIV-2 (Bio-Rad); and HIV Tridot (Mitra & Co., India).

39.2.2 List two: EIA tests

- Enzygnost Anti-HIV 1/2 Plus (Dade Behring AG)
- Detect HIV I+II (Biochem)
- HIV-Tetra, HIV-1+2 (Biotest)
- Recombingen HIV-1/2 EIA (Trinity Biotech plc)
- Innotest HIV-1/HIV-2 Ab s.p. (Innogenetics)
- HIV-Chex Searo only (Xcyton)
- HIV EIA (Labysystems)
- ICE HIV 1.0.2 EIA (Murex/Abbott)

- Vironostica HIV Uni-form II plus 0 (Organon Teknika)
- Genscreen HIV 1/2 (Bio-Rad)
- UBI HIV 1/2 EIA (United Biomedical)
- Abbott 3rd generation HIV-1/HIV-2 EIA (Abbott)
- HIV Ag/Ab combination assay (Murex)
- HIV-1/2 gO EIA (Abbott)
- Wellcozyme HIV recombinant (Murex)
- IV-2 (Genetic Systems)
- Genscreen plus HIV Ag-Ab (Bio-Rad), and
- HIV-1/HIV-2 Ab-capture ELISA test system (Ortho).

39.2.3 List three: Machine-dedicated immunoassays

- Imx HIV-1/HIV-2 plus (Abbott)
- AxSYM HIV 1/2 gO (Abbott)
- PRISM HIV O plus (Abbott)
- ADVIA Centaur HIV 1/0/2 (Bayer Healthcare), and
- Access HIV-1/2 CHLIA (Bio-Rad).

39.2.4 Confirmatory and supplementary tests

- Screening test negative—no further action is required.
- Screening test indeterminate—proceed to Immunoblot tests in List Four.
- Screening test reactive—a second supplemental test to clarify the status of the sample should be performed with one of the alternative screening tests in Lists One to Three or an immunoblot test from List Four. Acceptable supplemental tests are HIV-enzyme immunoassays and immunoassays, including Western-blot and line-blot tests.
- Supplemental enzyme immunoassay test reactive—immunoblot test may be used to confirm the diagnosis.

39.2.5 List four: Confirmatory assays

- Inno HIV Confirmation (Innogenetics)
- Inno-LIA HIV-1/HIV-2 Ab (Innogenetics)
- New LAV Blot I (Bio-Rad)
- New LAV Blot II (Bio-Rad)
- HIV-1 Blot 1.3 (Genelabs)
- HIV-1 Blot 2.2 (Genelabs), or
- RIBA HIV-1/HIV-2 SIA (Chiron).

39.2.6 Confirmatory test equivocal or indeterminate

The test should be repeated, when a nucleic-acid test also should be performed, if a suitable sample can be obtained. It should be noted that RNA nucleic-acid tests may give false-positive results in HIV-negative persons. The level of false reactivity usually is low.

The most suitable test is a DNA nucleic-acid test but these tests presently are not available commercially.

Available RNA nucleic-acid tests are:

- Amplicor HIV-1 test 0743925, 0743992, 9744034 (Roche)
- Quantiplex HIV-1 RNA bDNA 3.0 (Chiron)
- Nuclisens HIV-1 QT amplification and detection reagents (Organon)
- Amplicor HIV monitor test version 1.5 (Roche), and
- Cobas Amplicor HIV-1 monitor, version 1.5 (Roche).

39.2.7 Identity of applicants

The identity of applicants must be confirmed to prevent substitution. At least two separate coded identifiers should be obtained to accompany the sample. Specimens should preferably not be labelled with the applicant's name due to privacy reasons. The panel doctor should retain the register connecting the coding to the applicant's name. When the pathology result is received, the panel doctor should write the applicant's name on the result prior to sending the report with form 26.

39.2.8 Use of accredited laboratories

Panel doctors are responsible for the selection of suitably accredited laboratories to perform HIV testing. Panel doctors should have confidence in their chosen laboratory's security of samples, chain of custody for handling specimens in transport and within the laboratory, use of coding for specimens, that date-expired test kits are not being used, and that applicants are never able to access their samples or coding information. The original laboratory report must be stapled to form 26.

39.2.9 Pre-test counselling

Before an HIV test is performed, pre-test counselling should be provided to the applicant by the panel doctor. In some circumstances, an individual other than the panel doctor, such as a HIV/AIDS worker employed by the panel doctor in his/her clinic, will order the test and should provide pre-test counselling. Regardless of who provides basic pre-test counselling, the panel doctor should also explain:

- that the HIV-test is required as a part of the health examination
- the nature of HIV infection and the acquired immunodeficiency syndrome
- that the results of the test will be provided to Australian Government health agencies, and
- the concept of a false positive screening test.

To download a PDF file of the IOM Guide for HIV Counsellors: Counselling in the context of Migration Health Assessment, IOM, May 2006, see: www.iom.int/

39.2.10 Positive result

If an applicant's blood gives a HIV positive result, on the initial and/or confirmatory tests, the panel doctor should arrange for a second consultation and then refer the applicant to his or her own doctor for follow-up counselling and management. The panel doctor must record on form 26 that the applicant has been counselled. The following points should be covered in such counselling:

- information about the tests
- 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, and
- referral for early medical intervention.

If asked about the effect a positive result may have on an applicant's likelihood of meeting the health requirement, the panel doctor should state that this is a matter for a MOC to consider. Any further inquiries by applicants should be referred to the post.

39.3 HIV alerts

If an applicant has a positive HIV result, the panel doctor must immediately (within 48 hours of the examination) notify HOC, by email or fax, pending further results.

Details required for a notification of a positive HIV case are:

- family name
- given names
- date of birth (dd/mm/yyyy)
- passport number
- country of citizenship
- visa subclass number, and
- office where the application lodged (if known)

Panel doctors should notify HOC even if the applicant indicates that they are withdrawing from the process. Acknowledging the applicant's privacy, this information must be marked Medical in Confidence and only be referred to HOC via:

- the website: www.immi.gov.au/gateways/panel_doctors
- email: Health.Operations.Centre@immi.gov.au
- fax: +61 2 8666 5900 / 5901

40 Questions 21–22: Hepatitis B and C

Doctors should undertake venepuncture. If another person performs venepuncture, the doctor must assume accountability for the security of the process. Pre-test and post-test counselling for Hepatitis is required.

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	Hepatitis C antibody test
Pregnant women	Yes	No
Children for adoption Children who have been, or are to be, adopted by Australian residents	Yes	No
Unaccompanied minor refugee children	Yes	No
High-risk applicants • any person whom the panel doctor considers to be at high risk of hepatitis B or C infection, • persons with a history of hepatitis, jaundice or blood transfusions, • persons showing clinical evidence of hepatitis B or hepatitis C infection, • persons with tattoos IF extensive or suspected as having been done in un-sterile conditions	Yes	Yes
Hospital and healthcare workers All temporary visa applicants intending to work as, or study to be a doctor, nurse, paramedic or dentist.	Yes	Yes

If an applicant is either hepatitis B surface antigen or hepatitis C antibody seropositive, the panel doctor should test for the alternative hepatitis strain not already tested for, in addition to performing liver function tests and HIV tests. In hospital and healthcare workers only, (see above), if HepB sAg is positive then applicants should have HepB eAg status investigated. Only if this is positive should DNA studies be undertaken to look for viral load. In regard to HepC, if this is positive in health care workers then RNA studies are required (as well as the usual LFT's +/- liver USS).

The report(s) should be attached to, and the results entered on, form 26 before it is returned to the office processing the application. All members of a hepatitis B carrier's family, whose own hepatitis B surface antigen tests are negative, should be advised of the desirability of hepatitis B vaccination.

41 Question 23: Venereal Disease Reference Laboratory test

A Venereal Disease Reference Laboratory (VDRL) test, Rapid Plasma Reagin (RPR) test or equivalent test for syphilis should be arranged, the report attached (including titres) and the results included on form 26 for:

- any applicant whom the panel doctor suspects may be infected with a sexually transmitted disease, and
- all refugee applicants 15 or more years of age who are living in, or who recently have lived in, camp-like conditions.

If the screening test is positive, panel doctors should undertake a Fluorescent Treponemal Antibody (FTA) test. If the result of the FTA test is also positive, refer the applicant to their regular doctor for treatment. Confirm that the applicant has been treated and note the results on form 26.

42 Question 24: Recommendation A or B

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

A grade: Applicants without significant conditions or findings
B grade: Applicants with significant conditions or findings

The most important decision is whether or not a condition or finding is significant.

42.1 When is a condition or finding significant?

A significant condition or finding has current or future implications for the applicant's health and/or functional capacity. Any condition is considered significant if it:

a. represents a possible public health risk, and/or
b. is likely to require substantial medical treatment either now or in the future, and/or
c. negatively impacts the applicant's capacity for independent living, and/or
d. negatively impacts the applicant's intended activity in Australia, and/or
e. presents a barrier to travel.

Important examples of significant conditions are TB, HIV, organ failure, diabetes, psychiatric illness, and intellectual or physical disability. When significant abnormalities are detected, panel doctors should refer the applicant to an appropriately qualified and reputable specialist immediately, without waiting for a request from the MOC. This expedites processing of the application and ensures that MOCs have the best available information when making recommendations.

If in doubt, contact HOC by email to clarify the grading.

42.2 When is a condition or finding not significant?

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

42.3 'A' recommendations

'A' should be written when all the criteria below are met:

- No significant conditions or findings are noted.
- The physical findings are completely normal, including a blood pressure at or below the recommended levels, no significant cardiac murmur, no albumin, glucose or blood in the urine, and a visual acuity corrected if necessary, of no worse than 6/12 in the better eye.
- No medical or surgical condition is present which would require further investigation or treatment currently or in the foreseeable future (say, the next 10 years).
- The applicant can cope independently with the activities of daily living without family or other assistance. Nursing or institutional care is not required currently or in the foreseeable future (in the next 10 years, or 3 to 5 years in persons 70 or more years of age—see Attachment 3: Activities of Daily Living (ADL) Assessment.
- The results of the chest x-ray examination are completely normal, except for conditions listed in part C, page 49.

Where any condition or indication identified is stable and of no clinical significance, A is the appropriate recommendation.

42.4 'B' recommendations

B should always be written when any of the above conditions are not met, when conditions or findings are present, or if the panel doctor has reservations about an applicant's fitness, notwithstanding the absence of abnormal findings. Doctors should note that the grading does not determine whether a visa will be granted. Further, a B grading does not mean that an applicant will not meet the health criteria. The grading is simply a means of processing forms efficiently.

For details on the recommendations to be given for commonly seen conditions, please refer to Attachments 4 and 5.

43 Question 25: Declaration by examining doctor (for protection visa applicants only)

This part must only be completed for applicants within Australia who are applying for protection visas.

44 Question 26: Declaration by examining doctor

In making the declaration, the panel doctor must ensure the following:

- Date and place of the examination are completed accurately.
- The panel doctor's name must be printed or stamped clearly on form 26. The name must be that which was provided to HOC in the panel appointment application. The use of all other versions of a panel doctor's name (for example, aliases) is unacceptable, and
- The panel doctor must sign the declaration once the results of the physical examination are recorded fully and the doctor has completed his or her comments on the examination and on any additional reports and tests which may have been performed.

In signing the declaration, the panel doctor is acknowledging responsibility for the integrity and quality of the entire health examination process. DIAC randomly audits health examinations and any evidence of failure to maintain integrity or quality of the examination will result in closer scrutiny and possible removal from the panel.

Part C: For panel radiologists

Form 160

45 Taking the chest x-ray

Dr R.N. Bowry, panel radiologist from Nairobi in Kenya, has provided this very useful summary of the key quality control aspects the radiographers should be aware of:

45.1 Radiographic technique

- All chest x-rays should be taken in the posteroanterior (PA) projection to reduce cardiac magnification.
- In a correctly exposed film, the penetration should be such that one should be able to see the first four (4) vertebral bodies well (T1-T4), and the ribs, while the rest of the vertebrae should be just visible through the heart shadow.
- In an over-penetrated film, faint soft tissue lesions can be easily missed.
- In an under-penetrated film, pulmonary infiltrations can be over-diagnosed.
- If there is a slight over-penetration, a bright spotlight should be used to examine the radiograph.
- Routine chest x-rays should be taken in full inspiration. This lowers the diaphragm to the level of the 10th or 11th rib posteriorly.
- The position of the patient should be such that the medial ends of the clavicles are equidistant from the spinous processes of the thoracic vertebrae.
- Rotation of the chest can make the side nearer to the film appear less translucent.
- The scapulae should be clear of the lung fields.
- The x-ray beam should be centred at T5 or T6 vertebral body.
- The distance of the x-ray tube to the film should be 6 feet (150 cm).
- All chest x-rays should include costophrenic angles.
- Apices should be clearly seen (without overlying clavicles).
- If the lungs are of different translucencies one should consider:
    - rotation
    - poor screen/film contact in the cassette
    - absent breast
- Ensure that the following artefacts are excluded:
    - braided hair overlying the apices can mimic a lesion
    - development artefacts
    - static marks
    - dirty screens
    - nail marks
    - foreign bodies in cassettes
- When there is constant difference in the translucency between the right and left side of chest x-ray, ensure that the filter in the tube assembly is correctly positioned.

45.2 Special views

An apical lordotic view should be done for suspicious opacities over ribs, clavicles or other structures and a lateral decubitus view for costophrenic angle blunting to exclude pleural effusion.

45.3 Radiation safety

Please observe:

- routine use of lead shielding
- selection of correct film size
- x-ray beam collimation (narrowing of the beam so that only the target area is exposed), and
- not performing additional x-rays unless clinically indicated or requested by DIAC.

45.4 Film size

Full-size (42cm x 35cm approximately) posteroanterior films should be submitted for routine x-ray examinations of the chest.

If this is unavailable, then a minimum film size of 18cm x 24cm or 8” x 10” is required.

45.5 Film endorsements

The x-ray film plate must bear the date of the examination, applicant’s name in English, date of x-ray, and x-ray clinic in Roman script on a flashed label. The file number or passport number should be included if entered on form 160 by the processing office.

In rare cases when automatic transcription is not possible, the applicant’s details should be written in Roman script on the x-ray film in indelible white ink.

45.6 X-ray images on compact disc

In general x-ray images on compact disc are not to be submitted in lieu of x-ray film. Digital x-ray images should be printed on x-ray film and cost of printing should be passed to the visa applicant.

X-ray images can be submitted on compact disc ONLY if:

- The radiological report (form 160) has been completed by a panel radiologist in one of the following countries: Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Malta, Netherlands, New Zealand, Norway, Sweden, Switzerland, United Kingdom, United States of America. X-ray images on CD from countries not on this list will NOT be accepted.
- The radiological report (form 160) has been graded A (no abnormal findings present).

If the radiological report (form 160) is graded B (abnormal findings present) then a hard-copy x-ray film must be submitted.

45.7 Women

It is common to request x-rays for women of reproductive age (some of whom will be unknowingly pregnant at the time of the x-ray). Panel radiologists have an ethical obligation to ensure that these applicants are adequately protected. Please be vigilant in avoiding unnecessary radiation exposure. See page17 for further information.

45.8 Children

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

46 Film examinations and reports

The x-ray film is to be read by the panel radiologist, who should complete form 160. The correct name, date and anatomical side markers should be included. Look at the so-called ‘hidden’ areas including:

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

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

If significant abnormalities, such as changes suggestive of active TB, are detected, the radiologist should refer, or advise the panel doctor to refer, the applicant to an appropriate specialist immediately without waiting for such a request from the Australian authorities.

This will expedite the processing of the application, ensure that MOCs have the best available information when making recommendations, and that the applicant receives appropriate and early treatment.

Radiologists also must inform HOC immediately (within 48 hours of the examination) when changes suggestive of active TB have been noted in a chest x-ray film (see page 32).

Radiologists must not leave any part or item of form 160 incomplete as it will not be accepted by DIAC and will result in undue delays and costs for the applicant. Ongoing failure to complete forms is considered improper professional practice, and may be grounds for removal from the panel.

47 Grading A or B

Examples of findings that may be graded A include:

- breast implants
- rib abnormalities (for example, cervical ribs, previous rib fractures, bifd ribs)
- scoliosis
- nipple shadows
- dextrocardia
- azygous fssure/lobe (or other accessory fssures)

All other abnormalities, including cardiac and old TB, must be graded B.

In cases where chest x-ray indicates previous significant surgery, for example:

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

the radiologist should provide details and grade the case B.

48 Declaration by examining radiologists

In making the declaration, the panel radiologists must ensure:

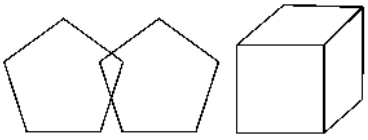
- Date and place of examination are completed accurately
- Their name and the radiology clinic's name is printed or stamped clearly on form 160. The clinic name must be the same name provided to HOC. The use of all other versions of a clinic's name is unacceptable, and
- They sign the declaration after the results of the radiological examination are recorded fully and they have completed his or her comments on the examination and on any additional reports or tests which may have been performed.

In signing the declaration, the panel radiologist is acknowledging responsibility for the integrity and quality of the radiological examination process. DIAC randomly audits all radiological examinations and any evidence of failure to maintain integrity and quality of the examination will result in closer scrutiny of the radiologist and possible removal from the panel.

Attachments

Attachment 1: Mini-mental state examination

(Adapted from Folstein)

Item	Score
Registration	
Give three words and warn the applicant that you will ask them to be recalled in three minutes time. Test immediate recall.	3
Attention/concentration	
2. Ask the applicant to count backwards from 100 in steps of seven (up to five steps) OR to spell the word, 'world', backwards.	5
Short-term memory	
3. Memory recall. Ask the applicant to recall the words given in question 1.	3
Language	
4. Ask the applicant to name two common items, as shown (pen, watch).	2
5. Ask the applicant to repeat the following sentence: 'No ifs, ands or buts'.	1
6. Ask the applicant to do the following three things with a piece of paper: pick it up with the left hand, fold it in half and put it on the floor. (Give all three instructions before handing over the paper).	3
7. Ask the applicant to do what is written on this piece of paper ('Close your eyes')	1
8. Ask the applicant to write a short sentence (must contain subject and verb and make sense).	1
Orientation	
9. Ask the applicant their address OR where you are now (street number, street, town, state, country).	5
10. Ask what today's date, day and season are (day, month, year, day, season).	5
Visuospatial skills	
11. Ask the applicant to copy this figure (intersecting pentagons OR a 3-dimensional cube). 	1
Total	30

This test should be made linguistically and culturally appropriate by panel doctors delivering it.

Attachment 2: Child development milestone guidelines

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

	Milestones given		Milestones given
Gross motor		Cognitive	
Chin up	1 month	Shows anticipatory excitement	3 months
Lifts head	4 months	Plays with rattle	4 months
Rolls—prone to supine	4 months	Plays peek-a-boo	8 months
Rolls—supine to prone	5 months	Finds hidden object	9 months
Sits unsupported	8 months	Pulls string to obtain toy	14 months
Pulls to stand	9 months	Activates mechanical toy	20 months
Cruises	10 months	Pretend play	24 months
Walks alone	13 months	Seeks out others for play	36 months
Walks up stairs	20 months		
Rides tricycle	36 months	Expressive language	
Hops on one foot	60 months	Coos	3 months
		Babbles	6 months
Fine motor		Da-da—inappropriate	8 months
Unfisting	3 months	Da/Ma—appropriate	10 months
Reach and grasp	5 months	First word	11 months
Transfer	6 months	Two to six words	15 months
Thumb-finger grasp	9 months	Two-word phrases	21 months
Tower of two cubes	16 months	Speech all understandable	27 months
Handedness	24 months	Names one colour	30 months
Scribbles	24 months	Uses plurals	36 months
Tower of four cubes	26 months	Names four colours	42 months
Tower of eight cubes	40 months	Gives first and last names	44 months
		Names two opposites	50 months
Social/self help		Strings sentences together	60 months
Social smile	6 weeks		
Recognises mother	3 months	Receptive language	
Stranger anxiety	9 months	Gesture games	9 months

Finger feeds	Milestones given	Understands ‘no’	Milestones given
	10 months		9 months
Uses spoon	15 months	Follows one-step command	12 months
Uses fork	21 months	Points to animal pictures	19 months
Assists with dressing	12 months	Points to six body parts	20 months
Pulls off socks	15 months	Follows two-step command	24 months
Unbuttons	30 months		
Buttons	48 months		
Ties shoelaces	60 months		
Dresses without supervision	60 months		

(Developmental guidelines drawn from General practice, 3rd edition**,** John Murtagh, McGraw-Hill, Sydney, 2003)

Attachment 3: Activities of daily living (ADL) assessment

Applicant's name: _____ Applicant's DOB: _____

Self-care	Intact	Limited	Helper	Unable
	Note performance without help		Note degree of assistance	
	With ease, no devices or prior preparation	With difficulty or with devices or prior preparation	Some help	Totally dependent
Food/drink	( )	( )	( )	( )
Dress upper body	( )	( )	( )	( )
Dress lower body	( )	( )	( )	( )
Puts on brace/prosthesis	( )	( )	( )	( )
Wash/bathe	( )	( )	( )	( )
Perineum (at toilet)	( )	( )	( )	( )
Sphincters' control	( )	( )	( )	( )
	Note control without help		Note frequency of accident	
	Complete voluntary	Control but with urgency, or use of catheter, appliance	Occasionally some help needed	Frequent or often wet/soiled
Bladder control	( )	( )	( )	( )
Bowel control	( )	( )	( )	( )
Mobility/locomotion	With ease, no devices or prior preparation	With difficulty, or with device or prior preparation	Some help needed	Totally dependent
Transfer bed	( )	( )	( )	( )
Transfer chair/wheelchair	( )	( )	( )	( )
Transfer toilet	( )	( )	( )	( )
Transfer bath/shower	( )	( )	( )	( )
Transfer car	( )	( )	( )	( )
Walk 50 metres—level	( )	( )	( )	( )
Stairs, up/down one floor	( )	( )	( )	( )
Walk outdoors—50	( )	( )	( )	( )
Wheelchair—50 metres	( )	( )	( )	( )

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

	Full	Moderate	Minimal	None
Communication	( )	( )	( )	( )
Comprehension	( )	( )	( )	( )
Expression	( )	( )	( )	( )
Social cognition	( )	( )	( )	( )
Social interaction	( )	( )	( )	( )
Memory	( )	( )	( )	( )

Current residence

( ) Own home ( ) Relative's home ( ) Personal care ( ) Hospital ( ) Other (please specify)

Time at above: _____ years _____ months

Current caregiver _____ Designation _____

_____ _____

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

Attachment 4: Guidelines for specific medical conditions

Condition	Temporary visa applicant	Permanent (migration) visa applicant
Arthritis	A grade if not requiring significant treatment, and unlikely to interfere with travel and intended activity in Australia.	A grade if minor with no interference with function. B grade if significant disease or affecting activities of daily living or working ability. Perform functional assessment, document treatment requirements and refer to specialist if indicated.
Back pain	A grade if unlikely to interfere with intended activity in Australia.	A grade if minor. B grade if condition interferes with work capacity or daily function. Document functional limitations, symptoms, and treatment needs.
Body mass index (BMI)	A grade if BMI 16–40. B grade if BMI<16 kg/m². Consider clinical reasons, for example, TB, cancer, malnutrition. A grade if BMI>40 kg/m² and there is no evidence of complications. B grade and refer to physician if complications of obesity are known or suspected. Report to address nature and severity of complications, treatment needs, and fitness for travel and stay in Australia.	A grade if BMI 16–40. B grade if BMI<16 kg/m². Consider clinical reasons, for example, TB, cancer, malnutrition. A grade if BMI>30 kg/m² and there is no evidence of complications. B grade and refer to physician if complications of obesity are known or suspected. Report to address nature and severity of complications, treatment needs, and fitness for travel and stay in Australia.
Cancer	A grade if applicant is recurrence-free >5 years post-treatment. B grade if evidence of recurrence exists, or if <5 years since treatment. Specialist report of staging at the time of diagnosis (including histopathology reports), details of primary treatment, examination findings, treatment needs, future prognosis, and excluding current recurrence.	Same as temporary.
Cardiac murmur	A grade if asymptomatic, healthy applicant and normal chest x-ray.	B grade and refer to cardiologist for opinion and consider echocardiogram.
Chest x-ray changes	A grade if the changes are anatomical variations and benign changes, including congenital rib abnormalities, bone cysts, accessory fissures, old rib fractures, cervical ribs, and scoliosis. B grade all pathological changes.	Same as temporary.

Condition	Temporary visa applicant	Permanent (migration) visa applicant
Diabetes IDDM	B grade and investigate if end-organ complications are known or suspected, including serum creatinine and resting ECG.	B grade and refer to an endocrinologist if end-organ complications are known or suspected. Specialist report to include serum creatinine, fundoscopy, urine albumin/creatinine ratio, resting ECG.
Diabetes NIDDM	A grade if stable with no evidence of end-organ involvement. B grade if unstable or if end-organ damage is suspected, and investigate as per IDDM above.	B grade if unstable, or if end-organ damage is suspected, investigate as per IDDM above.
Frail elderly	A grade if likely to be ft to travel to Australia, remain in good health for the duration of stay, and ft to return home. B grade otherwise and perform functional/ activities of daily living assessment, and document medical problems and treatment needs.	B grade and refer for geriatrician/ specialist physician assessment of medical conditions, cognitive function and ability to live independently. Undertake the activities of daily living assessment.
Hearing loss	A grade if hearing loss unlikely to interfere with intended activity in Australia. B grade otherwise and quantify hearing loss via whispered voice test or audiometry.	B grade if significant hearing loss, and quantify with audiometry. Refer for ENT assessment if an active process is suspected.
Hepatitis B surface antigen— positive	B grade and perform liver-function tests and hepatitis C test. Refer for gastroenterology assessment if LFTs elevated or if evidence of other complications.	Same as temporary.
Hepatitis C— positive	B grade perform liver-function tests and hepatitis B test. Refer for gastroenterology assessment if LFTs elevated or if evidence of other complications.	Same as temporary.
HIV—seropositive	B grade and obtain CD4 count and opinion from infectious disease physician regarding current and future management, any complications, and prognosis. Inform HOC by telephone or email within 48 hours.	Same as temporary.
Hypertension	A grade if stable and no evidence of end-organ involvement. B grade if unstable or end-organ involvement is suspected. Consider cardiologist referral.	B grade and refer for cardiology assessment, if end-organ involvement is known or suspected. Assessment to include cardiac echo, resting ECG, and exercise ECG (if indicated).

Condition	Temporary visa applicant	Permanent (migration) visa applicant
Hypo/ hyperthyroidism	A grade if uncomplicated. B grade if symptomatic or if complications are known or suspected.	Same as temporary.
Intellectual disability	B grade and document nature and degree of disability. If unlikely to interfere with intended activity in Australia, no further action is required. If likely to interfere with intended activity, obtain specialist assessment.	B grade and obtain specialist assessment.
Ischaemic heart disease	A grade if stable and asymptomatic. No further investigation required. B grade if unstable or symptomatic. Refer for cardiology assessment as per serial 103.	B grade if stable and asymptomatic. No further investigation required. If unstable or symptomatic, refer for cardiology assessment.
Multiple sclerosis, neurological disorders	See 'physical disability' below.	See 'physical disability' below.
Obesity	See 'BMI' above.	See 'BMI' above.
Physical disability	A grade if mild disability unlikely to interfere with intended activity in Australia. B grade if significant disability. Provide examination results, functional assessment, and comment on treatment needs. Refer to specialist if indicated.	A grade if mild, non-progressive, and no restrictions on daily living. B grade otherwise and provide details (including examination results and functional assessment). Refer for specialist assessment if indicated.
Pregnancy	Note restrictions regarding x-ray and requirement for hepatitis BsAg testing. If applicant consents to x-ray and hepatitis B is negative, assess as per routine. B grade if no x-ray.	Same as temporary.
Psoriasis	A grade unless evidence of arthritis then B grade.	B grade if severe or extensive disease.
Surgical history	A grade if past surgery has no impact on current health or function. B grade otherwise, including details.	Same as temporary.
Tuberculosis— suspicion of active disease	B grade and ensure you retain a copy of the x-ray film to assess applicant's progress. Refer applicant to a chest clinic for assessment immediately. Inform HOC by telephone or email within 48 hours.	Same as temporary.

Condition	Temporary visa applicant	Permanent (migration) visa applicant
Tuberculosis—no evidence of active disease	B grade and forward x-ray and (if possible) previous x-rays and/or treatment reports with the form 160.	Same as temporary.
Visual impairment	A grade if VA ≥ 6/12 in better eye. If VA ≤ 6/12 in better eye, can still A Grade if visual loss unlikely to interfere with intended activity in Australia. B grade if VA ≤ 6/12 in better eye and condition is likely to interfere with intended activity, or if active disease is suspected, refer for ophthalmology assessment.	A grade if VA ≥ 6/12 in better eye. B grade otherwise and comment on functional capacity. Refer for ophthalmology assessment.

Attachment 5: Examples of insignificant medical conditions

Any condition which does not impact on functional capacity or long-term prognosis can be graded A in all instances. Such conditions include: Medical findings:

- Acne
- Allergic rhinitis
- Asthma (controlled)
- Astigmatism (corrected)
- Breast fbroadenoma
- Caesarean section
- Dental disease
- Dermatitis
- Dyspepsia
- Eczema
- Fibrocystic disease
- Fibroids
- Haemorrhoids
- Heartburn
- HRT (hormone-replacement therapy)
- Hypercholesterolemia
- Hyperlipidemia
- Hypo/hyper thyroidism (uncomplicated)
- Infertility
- Keloids
- Lipoma
- Menopause
- Minor surgery such as appendectomy, cholecystectomy, cosmetic surgery, nasal operations or corrections, rhinoplasty and tonsillectomy
- Myopia
- Otitis externa
- Prostatic hypertrophy
- Refractive errors of vision (for example, myopia)
- Uterine fibroids (fibromyoma uteri)
- Varicose-vein surgery
- Vitiligo

X-ray findings:

- Breast implants
- Rib abnormalities (for example, cervical ribs, previous rib fractures, bifd ribs, congenital rib fusion)
- Scoliosis
- Nipple shadows
- Dextrocardia
- Azygous fissure/lobe (or other accessory fissures)
- Pectus excavatum