General guidance

This Guidance Note provides instructions to medical professionals on how to complete UNHCR's Medical Assessment Form (MAF), ensuring accurate, timely and comprehensive recording of pertinent medical information to help UNHCR staff to determine a person's eligibility and priority for resettlement on medical grounds.

Purpose of the MAF

The MAF assists UNHCR staff in determining an individual's eligibility for resettlement on medical grounds. The MAF, by itself, does not constitute a resettlement submission; however, it is an essential supporting document for a resettlement submission by UNHCR under the medical criterion of UNHCR's resettlement policy. The MAF is only valid for this purpose in conjunction with an authorized UNHCR resettlement dossier.

Who should fill in this form?

The MAF is a specialised medical form that requires medical knowledge and clinical training to complete. It records pertinent information derived from clinical findings and the interpretation of diagnostic tests. It must be completed in a detailed, clear and comprehensible manner while respecting medical ethics. Hence, only qualified medical professionals (physicians and rarely clinical officers with recognised formal training) may fill in this form.

Guidance for examining physicians

Fill in your name, date and place on the top of the MAF. Indicate whether this is an initial MAF or a follow-up MAF. Indicate the date of previous MAF if known or leave blank if unknown.

1 Patient Information (Page 1): Enter information about the individual you are examining, not the information of the head of the household or caregiver (if different).

2 Medical History (Page 1): This section aims at obtaining information on the patient's medical history regarding previous and current medical complaints and conditions.

Section 2.1: Record any significant previous medical condition(s) such as chronic conditions, major surgical interventions or disabilities. Use the available space to elaborate, including if applicable, onset, severity, requirements for follow-up, medication etc... Report also on smoking and alcohol habits, drugs use, drugs allergy, and obstetric history for women.

Section 2.2: List any current relevant medical condition(s). List the primary and/or secondary medical conditions, if any. Record the onset, cause, course, risk factors, main symptoms and specify whether it (they) have been confirmed, and by which means. Note that Section 3 on page 2 is dedicated to the clinical assessment of the main medical condition(s).

3 Clinical Assessment (Page 2): Record the observations of the physical examination and summarise the relevant findings. List any pertinent diagnostic tests and/or investigative procedures that have been done. Note that suggestions for further investigations/tests can be made under Section 4 on page 3.

Include the dates, results and place of the diagnostic investigations/tests/procedures. Be sure to attach to the MAF hard copies of investigation reports and/or diagnostic tests.

Section 3.2: Diagnosis: Based on the medical history, physical examination and investigation/test results enter the most likely diagnosis and/or an alternative hypothesis of the condition in the grey box. Space is provided for diagnosing the primary, and if applicable, secondary and tertiary conditions. Use standard case definitions and indicate ICD codes if possible.

Section 3.3: Current Treatment/Care/Interventions: List any medication(s), course of therapy, medical care, surgery, rehabilitation care, interventions or long-term therapy that the patient is currently undergoing. Record medications in their generic drug name, type and dosage as well as start and end dates (if applicable).

Section 3.4: Severity of Condition and Prognosis (Page 3): Describe the stage or severity of the condition, how it affects the patient's quality of life and the progression that the condition will likely occur under the current treatment/care and in the current environment. If possible, estimate the life expectancy and forecast possible medical complications. Do not predict how the prognosis could be influenced by certain interventions and/or access to better therapeutic options. For this issue, see Section 6 on page 4.

4 Management of Individual (Page 3):

Section 4.1: Based on the available evidence, diagnosis and prognosis enter any recommended further investigation(s) or procedures.

Section 4.2: Elaborate on the adequacy and availability of the current therapeutic course and/or care plan. In the event that adequate treatment is not available and/or accessible by the patient, suggest feasible alternatives and provide details as to whether such alternative(s) would be available and accessible in the country or through means of temporary medical evacuation to a 3rd country. If you do not know as to the availability of treatment options, indicate this as unknown.

5 Activities of Daily Living (Page 3): Use the standard questionnaire in this section to assess the patient's ability to perform activities of daily living (ADL). ADLs are designed to measure the patient's level of self-sufficiency and independence in carrying out routine daily functions.

6 Recommended Course of Action (Page 4): Indicate which course of action among the pre-defined choices you would recommend. Base your decision on your findings; include the prognosis, current and recommended treatment availability as well as ADL assessment. Enter the corresponding letter code in the grey box. Provide additional comments to support your decision.

Section 6.1: Specify the timeframe recommended for the above described action. You can choose among three pre-defined categories. Read the definitions of all three categories before entering the letter code in the grey box.

Section 6.2: Indicate whether the patient requires special equipment facilities and/or arrangements in the event of travel and if so, specify the types of equipments/arrangements.

7 Confirmation of Accuracy (Page 4): Read the confirmation of accuracy clause; indicate your name, function and health facility/organisation that you are affiliated with before signing this form. Make sure that the form is duly filled and that the information contained in it is accurate to the best of your knowledge.

8 Patient Consent and Agreement of Disclosure of Information (Page 4): Any MAF is only valid after the written consent is obtained from the individual that is being assessed, or in the case of children under-age, their legal guardian. Patients must provide consent regarding disclosure of this information to UNHCR and relevant resettlement country authorities for the purposes of resettlement. It must be ensured that the individual has read, or has been read, the consent clause and understands it before providing consent through a signature or a thumb print.