



Date _____

Child's name _____
Last First MI

D.O.B. _____ Male _____ Female _____

Ethnicity _____

Medicaid number _____

Parent's/Guardian's name _____

Phone _____

Alternate phone _____

Street address _____ Apt. _____

City _____ ZIP _____ County _____

How long at this address? Years _____ Months _____

Previous address _____

Rent Own

Landlord's address _____

Landlord's phone _____

Does the child spend time at:

Daycare Head Start Preschool

Babysitter Relative/Friend Other

List addresses for checked box(es)

Name, address, phone _____
_____ Time spent _____

Name, address, phone _____
_____ Time spent _____

Physician's name _____

Physician's address _____

Physician's phone number _____

Test date _____ BLL result _____ µg/dL

Test method _____ venous _____ capillary

A. FAMILY ASSESSMENT

1. Number of children in household _____

Name	DOB	Relationship	Lead Tests
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Parent's occupations/hobbies _____

3. Are there any pregnant women in the household? yes no

a. Have the pregnant women been tested for lead? yes no

Results _____ Reason for testing _____

b. Has educational material been given to pregnant women? yes no

c. Occupation _____
Hobby _____

4. What does the parent/guardian think may be the source of the lead poisoning?

B. CHILD'S HEALTH STATUS AND HISTORY

C. REVIEW OF SYMPTOMS

Symptoms	Initial Visit Date	Follow-up Date
Abdominal pain		
Constipation		
Vomiting		
Extreme activity		
Excessive tiredness		
Irritability		
Other		

D. DEVELOPMENTAL DELAYS

Gross motor	
Fine motor	
Previous testing/evaluation	
Social skills	
Speech	

<p>E. ORAL TENDENCIES</p> <p>1. Has the child been observed mouthing or eating non-food substances? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>2. What does the child put in his/her mouth? <input type="checkbox"/> Hands <input type="checkbox"/> Toys <input type="checkbox"/> Windowsills <input type="checkbox"/> Magazines <input type="checkbox"/> Newspapers <input type="checkbox"/> Railings/Moldings <input type="checkbox"/> Doors <input type="checkbox"/> Furniture <input type="checkbox"/> Dirt <input type="checkbox"/> Other _____</p> <p>3. How often does the child put his/her hands or other objects in his/her mouth? <input type="checkbox"/> Never/Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often/Frequently</p> <p>4. Is the child a thumb/finger sucker/nail biter? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>5. Does the child use a pacifier? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>H. EATING HABITS (cont.)</p> <p>3. How many servings of fruit and vegetables does your child eat per day? _____</p> <p>4. How many servings per day does your child eat meat/eggs/dried beans? _____</p> <p>5. How many ounces of milk/yogurt/cheese does your child drink or eat per day? _____</p> <p>6. Does your child use a bottle? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>7. Do you use bottled water to prepare formula or other drinks for your child? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>8. Does the bottled water include fluoride? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>9. Does your child take a vitamin with iron or other supplements every day? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>10. Do you have any food, candy or supplements that were packaged in another country? <input type="checkbox"/> yes <input type="checkbox"/> no</p>
<p>F. SLEEPING AREAS</p> <p>1. Is there loose paint on nearby walls or the ceiling that could fall into the child's bed? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>2. Does the crib, furniture or windowsills show teeth marks? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>3. Is the child's bed near a window exposed to inside/outside sources of lead? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>I. PLAY HABITS AND ENVIRONMENTAL SAFETY</p>
<p>G. FOOD PREPARATION AND EATING AREA</p> <p>1. Is any paint peeling from ceilings or walls in the food preparation or eating areas? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>2. Are there any windows or doors in the food preparation area that could create lead dust? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>3. Do you use hot tap water when preparing food or bottles? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>4. Do you prepare or store food in or eat food from cans or pottery? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>5. Do you use glazed dishes or dishes made in a foreign country? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>1. Does your child hide and play quietly? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, where? _____</p> <p>2. Where else inside the house does your child play? _____</p> <p>3. Where does your child play outside? _____</p> <p>4. Does your child play in the basement? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>5. Does your child play on the porch? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>6. Has anyone in the home been diagnosed with asthma? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>7. Does anyone in the home have asthma now? <input type="checkbox"/> yes <input type="checkbox"/> no</p>
<p>H. EATING HABITS</p> <p>1. Is your child enrolled in the Women, Infants, Children (WIC Program)? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>2. How many meals and snacks per day does your child eat? _____</p> <p>At what times? _____</p>	<p>8. Do you have pets? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>9. Does anyone smoke in the house? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>10. Is there a garage/outbuilding on the property? <input type="checkbox"/> yes <input type="checkbox"/> no</p>

I. PLAY HABITS AND ENVIRONMENTAL SAFETY (cont.)	COMMENTS
<p>11. Are there mini-blinds in the sleep or play area? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>12. Are the cords on the mini-blinds out of reach of the child? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>13. Does your child play at the window? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>14. Does your child play with painted or metal toys, antique toys or toy jewelry? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>15. Do you keep all firearms in a locked gun safe? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>16. Do you utilize safety gates to prevent a child from entering a stairwell or other area that might present a danger to the child? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>17. Do you have operational CO detectors? <input type="checkbox"/> yes <input type="checkbox"/> no Do you have operational smoke alarms? <input type="checkbox"/> yes <input type="checkbox"/> no Do you have an operational fire extinguisher? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>18. Do you use safety products, i.e., child bathtub chairs and gates at swimming pools and other areas to prevent accidental drowning? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>19. Do you use indoor pesticides? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>20. Are you aware of any water problems or mold conditions? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<p>J. OBSERVATION OF DWELLING UNIT</p> <p>1. Exterior construction: <input type="checkbox"/> Painted <input type="checkbox"/> Brick <input type="checkbox"/> Other _____</p> <p>2. Is paint peeling or chipping from walls or ceiling? <input type="checkbox"/> yes <input type="checkbox"/> no If so, where? _____</p> <p>3. Is the house in a high traffic area or near an industry (i.e., foundry, lead smelter, battery recycling facility)? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>4. Are renovations occurring? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>5. Housekeeping practices <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor</p> <p>6. Overall condition of the house? <input type="checkbox"/> Good <input type="checkbox"/> Moderate <input type="checkbox"/> Poor</p> <p>7. Age of windows _____</p> <p>8. Has your home been tested for radon? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>9. Are you interested in information on how to obtain a test kit? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p>Staff conducting home visit _____ Case manager _____ Nurse signature _____ Today's date _____ Date of environmental investigation referral _____</p>

Care Plan/Assessment

Nursing Diagnosis: Elevated blood lead level as evidenced by confirmatory level of _____

Goal: The family will have an improved understanding of elevated blood lead levels and will carry out practices that will minimize lead exposure. The child will have decreased blood lead levels and will demonstrate optimal growth and development.

Intervention:			Date
1. Discuss possible sources of lead exposure (paint, occupation, cultural). Identify, if possible, the lead source.	Yes	No	
2. Conduct "visual assessment" of the child's environment.	Yes	No	
3. Discuss effects of elevated blood lead levels (IQ/behavior/growth).	Yes	No	
4. Review behaviors that put child at risk for lead exposure (hand mouth).	Yes	No	
5. Review housekeeping, cleaning, remodeling, hygiene.	Yes	No	
6. Discuss nutrition (iron, vitamin c, calcium, 3 meals, 3 snacks).	Yes	No	
7. Refer for environmental inspection, document referral.	Yes	No	
8. Explain need for follow-up testing.	Yes	No	
9. Refer or conduct developmental screening.	Yes	No	
10. Referrals to social service agencies/programs (WIC, Medicaid, FS).	Yes	No	
11. Physician contact.	Yes	No	
12. Provide educational materials.	Yes	No	
13. Offer radon information and access to testing kits.	Yes	No	
14. Offer indoor clean air quality education.	Yes	No	

Nurse signature _____

Date _____