|  |  |  |
| --- | --- | --- |
| **CLPPP** |  |  |
| **Lead Poisoning** |  |  |
| **Nursing Initial Home Visit** |  |  |  |



|  |
| --- |
| **Client Information:** |
|  |  |  |  |  |  |  |  |  |
| Case Child’s Name (Last, First, MI): |  | DOB: |  | Race: |  | Sex: |  | Ethnicity: |
|  |  |  |  |  |  |  |
| Child’s Primary Address: |  | City: |  | County: |  | Zip Code |
|  |  |  |  |  |
| Medicaid#: |  | HHLPSS ID# |  |  |
|  |  |  |  |  |
| PCP Name: |  | Address: |  | Phone #: |
|  |  |  |  |  |
| Alt. Medical Provider: |  | Address: |  | Phone #: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship:**  | **Age:**  | **Phone #:**  | **Occupation:**  |
| Mother  |  | Home  |  |
| Business |
| Father  |  | Home  |  |
| Business |
| Other  |  | Home  |  |
|  | Business |
| Other  |  | Home  |  |

|  |
| --- |
| **Alternate Contact Person**  |
| Name:  | Address:  | Phone #:  | Relationship:  |

|  |
| --- |
| **Child’s Lead Test History** |
| Date of Blood Draw: | Type (Capillary or Venous): | Lead Level: | Date of Blood Draw: | Type (Capillary or Venous): | Lead Level: |
|  |  |  |  |  |  |
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| --- |
| **Caregiver Information:** |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Caregiver is: |[ ]  Mother |[ ]  Father |[ ]  Foster Parent/Guardian |
|  |[ ]  Other | Specify: |  |
| Person Interviewed: |  |
| Primary language of the household: |  |
| What is the primary source of income for the family? |  |
| Does family receive: |
|[ ]  WIC |[ ]  Food Assistance |[ ]  Medicaid/Medicare/SSI/SSDI |
|[ ]  MI Child |[ ]  Maternal Infant Health |[ ]  Public Housing |
|[ ]  Other: Social service agency support, food pantry etc | [ ]   | Transportation Assistance |

|  |  |  |  |
| --- | --- | --- | --- |
| Does the family own or rent the property? |[ ]  Own |[ ]  Rent | If rented: |
| Owners Name: | Address: | Phone #: |
|  |
|  |

|  |  |
| --- | --- |
| Property Management Firm: |  |
| Other living arrangement (explain): |  |
|  |
|  |
|  |

|  |
| --- |
| **Child’s Health History:** |

|  |  |
| --- | --- |
| When was the last time your child was seen by the doctor? |  |

|  |  |  |
| --- | --- | --- |
| Do you have any concerns about your child’s health? |[ ]  Yes |[ ]  No |
| If yes, explain: |  |

|  |
| --- |
| Does the child have a history of (Check all that apply): |
|[ ]  Asthma |[ ]  Birth Defects |[ ]  Diabetes |[ ]  Heart conditions |[ ]  Sickle Cell |[ ]  Seizures |
| Other: |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| Is the child currently taking prescribed medications? |[ ]  Yes |[ ]  No |
| If yes, list medications: |  |

|  |  |  |
| --- | --- | --- |
| Does the child have a history of iron deficiency Anemia? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Do you know the child’s hemoglobin status? |[ ]  Yes |[ ]  No |
| If no, explain: |  |

|  |  |  |
| --- | --- | --- |
| Does your child have allergies? |[ ]  Yes |[ ]  No |
|  | If Yes, list medications: |  |
|  | If Yes, list foods: |  |
|  | If Yes, list any others: |  |

|  |  |  |
| --- | --- | --- |
| Is the child current with immunizations? |[ ]  Yes |[ ]  No |
| If no, explain: |  |

|  |  |  |
| --- | --- | --- |
| Is the doctor aware of your child’s blood lead history? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Has the child ever been hospitalized for lead poisoning? |[ ]  Yes |[ ]  No |
| If yes, specify dates: |  |

|  |  |  |
| --- | --- | --- |
| Has the child ever received chelation therapy? |[ ]  Yes |[ ]  No |
| If yes, specify dates: |  |

|  |
| --- |
| Is the child receiving or has the child been referred to Children’s Special Health Care Services? |
|[ ]  Receiving services |[ ]  Referred to services |[ ]  Neither |

|  |
| --- |
| Barriers to obtaining medical care: (Check all that apply): |
|[ ]  lack of medical insurance |[ ]  transportation |[ ]  language barrier |[ ]  not convenient for work schedule |
|[ ]  cannot find child care for other children |[ ]  literacy |[ ]  Other: |  |
| Comments: |  |

|  |
| --- |
| **Sibling Lead History:** |

|  |  |
| --- | --- |
| Comments: |  |
|  |  |
|  |  |

|  |
| --- |
| **Developmental Assessment:** |

|  |  |  |
| --- | --- | --- |
| Does the caregiver feel the child’s development is normal for his/her age? |[ ]  Yes |[ ]  No |
|  | If no, specific concerns: |  |
|  |  |

|  |  |
| --- | --- |
| Date of ASQ or other assessment: |  |

|  |  |
| --- | --- |
| Deficits noted? If yes, explain: |  |
|  |  |

|  |
| --- |
| **Nutritional Assessment:** |

|  |  |  |
| --- | --- | --- |
| Do you have food available for the family all days of the month? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Does your child have a good appetite? |[ ]  Yes |[ ]  No |

|  |  |  |  |
| --- | --- | --- | --- |
| How many meals does your child eat each day? |  | How many snacks? |  |

|  |  |  |
| --- | --- | --- |
| Do your child’s eating habits fluctuate frequently? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Does your child eat at the same times each day? |[ ]  Yes |[ ]  No |

|  |  |
| --- | --- |
| Where does your child usually sit to eat? |  |

|  |  |  |
| --- | --- | --- |
| Does your child eat at school/daycare? |[ ]  Yes |[ ]  No |
|  | If no, please describe: |  |
| Type of food: |  |

|  |  |  |
| --- | --- | --- |
| Does your child eat fruits and vegetables daily? |[ ]  Yes |[ ]  No |
|  | If no, please explain: |  |

|  |  |  |
| --- | --- | --- |
| Does your child take vitamins or dietary supplements (i.e., calcium, iron etc.)? |[ ]  Yes |[ ]  No |
|  | If yes, please list them: |  |

|  |  |  |
| --- | --- | --- |
| Does your child take any other nutritional supplements/herbal preparations or remedies from another country? |[ ]  Yes |[ ]  No |
|  | If yes, please describe: |  |

|  |  |  |
| --- | --- | --- |
| Does the family eat food grown in a garden? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Does your family thoroughly wash all fresh fruits and vegetables? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Does your child ever eat ethnic foods from another country? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Are food items stored in open cans or ceramic containers? |[ ]  Yes |[ ]  No |

|  |  |  |
| --- | --- | --- |
| Are handmade or imported ceramic dishes used in the home? |[ ]  Yes |[ ]  No |

|  |
| --- |
| What containers are used to prepare, serve, and store the child's food? |
|  |

|  |  |  |
| --- | --- | --- |
| Does your child have a favorite cup or eating utensil? |[ ]  Yes |[ ]  No |
|  | Is it handmade or ceramic? |[ ]  Handmade |[ ]  Ceramic |

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| --- | --- | --- | --- | --- |
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| --- | --- |
| Additional Comments: |  |
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| --- |
| **List foods and amounts eaten by the child in the last 24 hours:** |
| Breakfast | Lunch | Dinner | Snacks |
| Grains |  |  |  |
| Vegetables |  |  |  |
| Fruits |  |  |  |
| Milk |  |  |  |
| Meat and Beans |  |  |  |
| Liquids (Water, juice, soda) |  |  |  |

|  |  |  |
| --- | --- | --- |
| Is this typical of your child’s diet? |[ ]  Yes |[ ]  No |

**If no, complete the next section**.

**Record the frequency with which the child eats the following foods:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Foods** | **Daily** | **Weekly** | **Never** |
| Cheese, yogurt  |  |  |  |
| Chicken, Beef, Pork, Poultry  |  |  |  |
| Fish and shellfish  |  |  |  |
| Eggs  |  |  |  |
| Dried Beans, Peas, Peanut Butter  |  |  |  |
| Bread, Crackers, Cereal, Macaroni, Spaghetti, Tortillas, Pasta  |  |  |  |
| Whole Milk  |  |  |  |
| Skim or Low-fat Milk  |  |  |  |
| Breast Milk  |  |  |  |
| Formula  |  |  |  |
| Fruit, Fruit Juice  |  |  |  |
| Vegetables  |  |  |  |
| Potatoes  |  |  |  |
| Soft Drinks  |  |  |  |
| Pastry Desserts, Ice Cream, Desserts  |  |  |  |
| Candy  |  |  |  |
| Chips, Snacks or other high fat foods  |  |  |  |

**Compare these lists to the food guidelines appropriate for the child’s age.**

|  |  |
| --- | --- |
| **Comments:** |  |
|  |  |

|  |
| --- |
| **Social History** |

|  |  |
| --- | --- |
| How long has the child lived at this address? |  |

**List all locations where the child currently spends or within the past two years has spent more than 20 hours a week.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Address:** | **Facility:** | **How Long at Address:** | **Contact Name:** | **Phone #:** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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| --- | --- |
| Where does your child spend most of his/her time when at home? |  |
| Where is your child’s most frequent play area? |  |

|  |
| --- |
| **Check the answer that applies.** |
| Does family remove shoes when entering the house? |[ ]  Yes |[ ]  No |
| Does family have a pet that could track contaminated soil/dust from outside? |[ ]  Yes |[ ]  No |
|  | If yes, where does the pet sleep? |  |  |  |
|  |  |  |  |  |
| Does child play in, live in, or have access to areas where shellacs, dyes, etc. are kept? |[ ]  Yes |[ ]  No |
| Does your child ever play in the yard or the dirt near the house? |[ ]  Yes |[ ]  No |
| Does your child ever play on the porch or painted steps? |[ ]  Yes |[ ]  No |
| Does your child play in areas of chipping or deteriorated paint? |[ ]  Yes |[ ]  No |
| Does your child play at a park or playground? |[ ]  Yes |[ ]  No |
|  | If yes, specify location:  |  |  |  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| Does your child wash his/her hand before eating snacks or meals, after playing outside, at bedtime, and naptime? |[ ]  Yes |[ ]  No |

Mouthing activity is normal in young children; does your child do any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
|  |[ ]  sucks fingers |[ ]  eats/chews paint chips |  |
|  |[ ]  picks at painted surfaces |[ ]  eats soil |  |
|  |[ ]  puts painted objects in mouth |[ ]  puts matches in mouth |  |
|  |[ ]  puts soft metal objects in mouth |[ ]  puts old or foreign printed materials in mouth |  |
|  |[ ]  sucks on or eats other non-food items(i.e., mini-blinds) |[ ]  plays with cosmetics/hair preparations metal objects or talc or puts them in mouth |  |

|  |  |  |
| --- | --- | --- |
| Has anyone in the household recently traveled outside the U.S.? |[ ]  Yes |[ ]  No |
|  | If yes, who and to what countries? |  |

|  |  |  |
| --- | --- | --- |
| Does anyone in the household use paints, pigments, facial cosmetics, or hair coloring containing lead? |[ ]  Yes |[ ]  No |
|  | No If yes, explain: |  |

|  |  |  |
| --- | --- | --- |
| Does anyone in the household use or have access to imported cosmetics, folk medicines, or non-prescription medication or ethnic foods? |[ ]  Yes |[ ]  No |

|  |
| --- |
| **Check the answer that applies.** |
| Are there imported non-glossy vinyl mini blinds in the house? |[ ]  Yes |[ ]  No |
| Is there an industrial area within one mile of the house? |[ ]  Yes |[ ]  No |
|  | If yes, type of industry? |  |  |  |
|  |  |  |  |  |
| Has any renovation work been done in the past six months? |[ ]  Yes |[ ]  No |
| Have you or anyone in the household had lead-safe work practices training? |[ ]  Yes |[ ]  No |
| Has painted wood ever been burned in a wood-stove or fireplace? |[ ]  Yes |[ ]  No |
| Have ashes ever been emptied onto soil? |[ ]  Yes |[ ]  No |
| Does your child play at a park or playground? |[ ]  Yes |[ ]  No |
| Were gasoline or other solvents ever used to clean parts or disposed of at the property? |[ ]  Yes |[ ]  No |
| Has soil ever been tested for lead? |[ ]  Yes |[ ]  No |
| Has the household water ever been tested for lead? |[ ]  Yes |[ ]  No |

|  |  |
| --- | --- |
| Comments: |  |
|  |  |
|  |  |

|  |
| --- |
| **Check all that apply:** |
| **Latino:** | **Cosmetics** |  |  |  |  |  |  |  |  |  |  |
|  | **Foods** |[ ]  Tamarind Candy |[ ]  Chile flavored candies |  |  |
|  |  |[ ]  Chocolate-Covered grasshoppers |  |  |  |  |
|  | **Remedies** |[ ]  Azarcon |[ ]  Liga |[ ]  Maria Luisa |[ ]  Alarcon |[ ]  Coral |
|  |  |[ ]  Rueda |[ ]  Greta |[ ]  Albayalde |[ ]  Litargiri |  |  |
| **Middle Eastern, Indian, Pakistani, African:** | **Cosmetics** |[ ]  Alkohl |[ ]  Kohl |[ ]  Saoott |[ ]  Surma |[ ]  Henna |
|  |  | □ | Sindoor | □ | Kum Kum |  |  |  |  |  |  |
|  | **Foods** |[ ]  Lozeena |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | **Remedies** |[ ]  Bali Goli |[ ]  Ghasard |[ ]  Kandu |[ ]  Ayurvedic |[ ]  Kushta |
|  |  |[ ]  Deshi Dawa |[ ]  Bint Dahab |[ ]  Santrinj |[ ]  Bokhoor |  | Cebagin |
|  |  |  | Al Murrah |  |  |  |  |  |  |  |  |
| **Southeast Asian, Chinese** | **Cosmetics** |  |  |  |  |  |  |  |  |  |  |
|  | **Foods** | □ | Plum Candy | □ | Ginger Candy |  |  |
|  | **Remedies** |[ ]  Chuifong Tokuwan |[ ]  Jin Bu Huan |[ ]  Po Ying Tan |[ ]  Ba-Baw-San |[ ]  Pay-Loo-Ah |
|  |  |[ ]  Hai Ge Fen |[ ]  Ju Hua |[ ]  Litharge |[ ]  Cordyceps |  |  |
| **Other:** |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Does anyone living in the household or regularly visiting do any of the following as a hobby or occupation? |[ ]  Yes |[ ]  No |

|  |  |  |  |
| --- | --- | --- | --- |
|  |[ ]  Home renovation (HVAC, plumbing, painting) |[ ]  Auto repair(radiator or body work) |  |
|  |[ ]  Furniture refinishing |[ ]  Electronics soldering |  |
|  |[ ]  Glass or metal soldering |[ ]  Jewelry making/crafts |  |
|  |[ ]  Glazed-pottery making/Ceramics |[ ]  Target shooting |  |
|  |[ ]  Stained-glass making |[ ]  Fishing or hunting |  |
|  |[ ]  Artistic painting |[ ]  Making bullets, slugs, or fishing sinkers |  |
|  |[ ]  Landscaping/Gardening |[ ]  Construction  |  |
|  | □ | Welding |  | Type: |  |
|  | □ | e-recycling |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Do any adults, involved with the hobbies or occupations listed above, change out of their work clothes as soon as they get home? |[ ]  Yes |[ ]  No |

|  |
| --- |
| **Child’s Physical Assessment Results** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Height:** |  | (in/cm) | **Weight:** |  | (lbs/kg) |[ ]  Per parent report |
| **Initial Birth Weight:** |  | (libs/kg) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Level of attention:** |[ ]  Appropriate |[ ]  Somewhat distractible |[ ]  Very distractible |
|  |[ ]  Other: |  |  |
|  |  |  |
| **Interest in Surroundings:** |[ ]  Alert |[ ]  Somewhat disinterested |[ ]  Seriously disinterested |
|  |[ ]  Other: |  |  |
|  |  |  |
| **Behavior:** |[ ]  WNL for age |  |  |  |  |
|  |  | Other: DESCRIBE any instances of impulsivity, difficulty following instructions, aggressiveness toward others observed during visit |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |
| **General Appearance:** |[ ]  Well-nourished |[ ]  Obese |[ ]  Thin |
|  |[ ]  Other: |  |  |
|  |  |  |
| **Skin:** |[ ]  WNL |[ ]  Laceration |[ ]  Bruises |[ ]  Rashes |
|  |[ ]  Other: |  |  |
|  |  |  |
| **Stool:** |[ ]  Toilet trained? |[ ]  Toilet training begun? |  |  |
|  |  | Last BM: |  | Usual Pattern: |  |  |
|  |  | Other: |  |  |
|  |  |  |  |  |
| **Bladder:** |[ ]  Toilet trained? |[ ]  Toilet training begun |  |  |
|  |  | Other: |  |  |
|  |  |  |
| **Muscles:** |[ ]  WNL |[ ]  Movement impaired |  |  |
|  |[ ]  Other: |  |  |
|  |  |  |
| **Adaptive Devices:** |[ ]  Eye glasses |[ ]  Hearing Aide |[ ]  Wheelchair |
|  |[ ]  Other: |  |  |
|  |  |  |

|  |
| --- |
| **PROPERTY ASSESSMENT:****Based on direct visual observation by interviewer. Must be completed by PHN if Environmental Investigation is not done at time of IHV or if local protocol does not require Environmental Investigation** |

|  |  |  |
| --- | --- | --- |
| Is dwelling located within 2 blocks of a major roadway, freeway, elevated highway, other transportation structure or industrial area? |[ ]  Yes |[ ]  No |
| Is any part of the home currently being renovated or repaired? |[ ]  Yes |[ ]  No |
| Are nearby buildings or structures being renovated, repaired or demolished? |[ ]  Yes |[ ]  No |
| Is there chewed paint on: Woodwork, toys, or furniture? (Circle all that apply) |[ ]  Yes |[ ]  No |
| Is there peeling paint on: Woodwork, toys or furniture? (Circle all that apply) |[ ]  Yes |[ ]  No |
| Is there deteriorated paint on outside of fences, garages, play structures, railings, building siding, windows, trims, or mailboxes? |[ ]  Yes |[ ]  No |
| Are there visible paint chips at the perimeter of the house, fences, garage, or play structures? |[ ]  Yes |[ ]  No |
| Is there any evidence of hobbies or businesses that could cause contamination? |[ ]  Yes |[ ]  No |
| Is food prepared or stored in ceramic or pewter pots or stored in any glazed or earthenware containers? |[ ]  Yes |[ ]  No |
| Are Liquids stored in metal, pewter, or crystal containers? |[ ]  Yes |[ ]  No |
|  | If yes, please explain: |  |  |  |
|  |  |  |  |  |

|  |  |
| --- | --- |
| **Comments:** |  |
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|  |  |
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| --- |
| **PROPERTY ASSESSMENT: Based on direct visual observation by interviewer.** |

|  |  |  |
| --- | --- | --- |
| **Room** | **Paint Condition** | **Observations and Temporary Measures Needed** |
| **Primary Play Area** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Living Room** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Dining Room** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Kitchen** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Family Room** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Child’s Bedroom** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Parent’s Bedroom** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Other Bedroom** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Bathroom** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Porch Entry** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |
| **Yard** |[ ]  Intact |  |
|  |[ ]  Not Intact |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Nurse’s Signature |  | Date |  |

**Additional notes:**