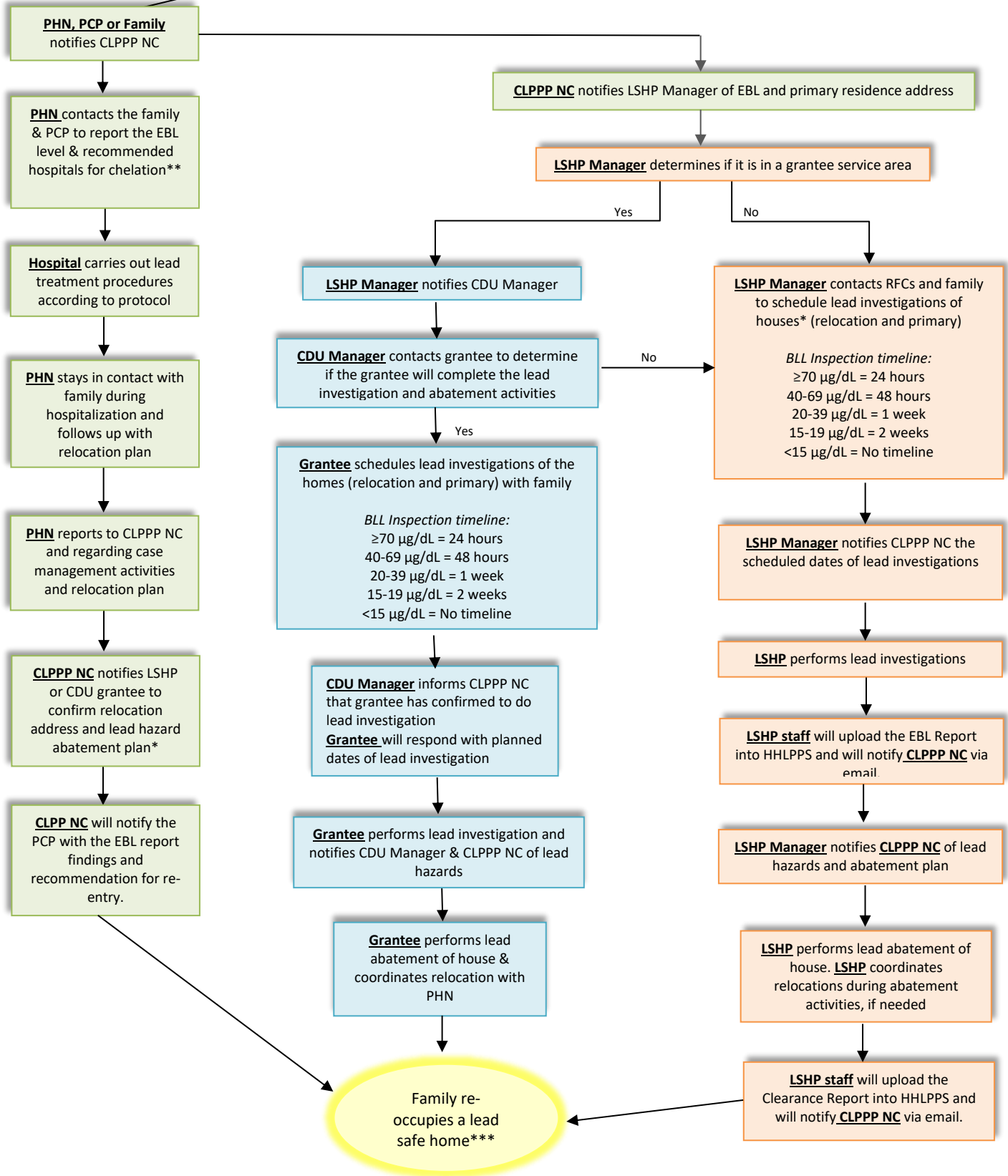


# Childhood Lead Poisoning Prevention Program & Healthy Homes Section Elevated Blood Lead Level Response Guide

Elevated blood lead test result received by the Childhood Lead Poisoning Prevention Program (CLPPP), local public health nurse (PHN), primary care provider (PCP) and/or family



\*≥ 40 µg/dL: No LSHP application needed prior to investigation. < 40 µg/dL: Respond on a case by case basis, determined by LSHP

\*\*See CLPPP Guide for further case management protocol on venous BLL ≥ 45 µg/dL

\*\*\*LSHP recommends that the child not return to a home with presumed or known lead hazards for hospitalized children

## Abbreviations:

**CLPPP:** Childhood Lead Poisoning Prevention Program  
**CLPPP NC:** Childhood Lead Poisoning Prevention Program Nurse Consultant  
**PHN:** Public Health Nurse  
**PCP:** Primary Care Physician  
**LSHP:** Lead Safe Home Program  
**CDU:** Community Development Unit  
**RFC:** Regional Field Consultant  
**EBL:** Elevated Blood Lead Level

## Contacts:

### **CLPPP:**

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**\*\*Main point of contact**

## Health Homes Section Information Form for Elevated Blood Lead Level Referral

Name of Child: \_\_\_\_\_

Birth Date of Child: \_\_\_\_\_

Blood Lead Level: \_\_\_\_\_

Date of Most Recent Blood Lead Test: \_\_\_\_\_

Type of Most Recent Blood Lead Test: Capillary or Venous

Is the Child Receiving Chelation: Yes or No      Hospital: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Primary Address: \_\_\_\_\_ How long at this address: \_\_\_\_\_

Previous Address (if <1 year at current address): \_\_\_\_\_

Relocation Address: \_\_\_\_\_

Hospital Referral: \_\_\_\_\_

Public Health Nurse Case Manager Name: \_\_\_\_\_

Public Health Nurse Case Manager Phone/Email: \_\_\_\_\_

Initial Contact Name: \_\_\_\_\_

Initial Contact Date: \_\_\_\_\_ Initial Contact Time: \_\_\_\_\_

Known Behavior (i.e. chewing, place of possible exposure): \_\_\_\_\_

\_\_\_\_\_

Notes: