Date

Provider Name

Address

City, State ZIP

Re: **<<Insert Child’s name>>**, **<<Insert Date of birth>>**:

Dear Dr. **<<Insert Physician Name>>**:

The **<<Insert LHD>>** has provided Elevated Blood Lead Nursing Case Management (EBL NCM) for **<<Child’s name>>**. The EBL NCM services for the child referenced above are now completed. We are writing to provide information on the EBL NCM services this child has received to date.

EBL NCM encompasses a range of activities designed to educate families about the dangers of lead poisoning and to connect them to supportive services. It includes:

* Conducting in-home nursing and developmental assessments to gain an understanding of the child and his/her family’s needs;
* Educating the family about sources of their child’s lead exposure and steps to minimize future exposure;
* Developing of a plan of care to reduce the child’s blood lead level;
* Coordinating an environmental investigation of the family’s home;
* Providing referrals for services, including home lead abatement services for eligible families;
* Educating the family to ensure follow-up testing until the child’s blood lead level is <4.5 ug/dL.

The attached report identifies NCM CM activities associated with this child.

If you have questions or concerns about the status of this child, or would like additional information about the services provided, please call us at **<<Insert LHD Phone Number>>**.

Sincerely,

**<<Signature>>**

**<<Typed Name>>**

**<<Title>>**

**<<LHD>>**

**<<Phone Number>>**

[cc/ Medicaid Health Plan if appropriate]

Revised 04/21/2020 1

# Elevated Blood Lead Level Nursing Case Management Services Provided to the Following Patient

Child’s Name: Date of Birth: Address: Parent/Guardian’s Name:

*PLEASE NOTE: The CDC recommends that the child’s permanent medical problem list includes his/her history of a confirmed elevated blood lead level.*

# EBL NCM Activities Provided (Check all that apply):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ☐ | Health Education | ☐ | Nursing Assessment | ☐ | Plan of Care |
| ☐ | Home Visit | ☐ | Visual Assessment of Home for Lead hazards | ☐ | Assist with LSHP Application |

**Referrals Made (Check all that apply):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ☐ | Re: Nutrition  *(Check all that apply):* | | ☐ | Re: Housing  *(Check all that apply):* | ☐ | Re: Medical services  *(Check all that apply):* |
|  | ☐ WIC  ☐ Food Pantry | |  | ☐ Lead home abatement  ☐ Relocation to lead safe housing |  | ☐ Medicaid/Medicare enrollment  ☐ Children’s Special Health Care Services enrollment |
| ☐ | Re: Household goods assistance  *(Check all that apply):*  ☐ *Clothing*  ☐ *Diapers*  ☐ *Furniture* | | ☐ | Re: Education  *(Check all that apply):*  ☐ *Early On*  ☐ *Head Start/Early Head Start* | ☐ | Re: Transportation  ☐ Bus Tickets  ☐ Taxi Voucher |
| ☐ | Other |  |  |  |  |  |

**Nursing Recommendations/Follow-up Activities/Case Disposition**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Revised 04/21/2020