

**INDIANA LEAD AND HEALTHY HOMES PROGRAM
LEAD POISONING HOME VISIT FORM**

RETURN WITHIN 10 BUSINESS DAYS

Interviewer:	Date of Home Visit:
Agency:	
Person Interviewed:	Relationship:

PATIENT INFORMATION

Last Name:		First Name:	
Address:		Medicaid#:	
City: _____, IN		Social Security#:	
Zip Code:	Length at Residence: ____ Years ____ Months		
EBL LEVEL: Venous / Capillary		BLL TEST DATE:	
Is this an Initial Home Visit?: Yes ____ No ____			
Birth Date:	Age:	Sex: Male ____ Female ____	
RACE: African American ____ Native American ____ Asian/Pacific Islander ____ Caucasian ____ Multi-Racial ____ Other ____ Unknown ____			
Ethnic Origin: Hispanic ____ Non-Hispanic ____ Unknown ____			
Parent/Guardian Name:		Relationship to Child:	
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____			
Is mother pregnant? Yes ____ No ____			
Who to contact if you move?:	Name:	Phone Number:	

List where child has lived in the past 12 months:			
Address	City/State	County	Years/Months

Other household members: *Note children less than seven years of age, pregnant women and adults employed in jobs that may expose them to lead.*

Name	Relationship to Child	Date of Birth	Age	Occupation

List where child spends more than six hours a week, other than home:

Name of Location	Address	Phone Number	Time Spent at Location

MEDICAL INFORMATION

Has child ever been hospitalized?: Yes _____ No _____
If yes, when and why?:
Does child have any other medical conditions or health issues?:
Does child have any behavioral issues/problems?:

Physician/Provider/Clinic Name:		
Address:	City: _____, IN	
Zip Code	County:	Phone Number:

Do any adults in the household work in a lead industry?

(Lead smelters and foundries, radiator repair shops, battery manufacturers, construction, glass and ceramic industries, etc...)

Who?	What Occupation?	How long employed there?	Is clothing changed before leaving work?	Is shower taken before leaving work?	Is routine blood lead test given?

Does anyone in the home have a hobby involving lead?
(Soldering, stained glass, bullet making, ceramics, working on cars, etc...)

Does anyone in the home use any off brand or imported cosmetics?
(Nail polish, lipstick, skin cream, eyeliner, etc...)

Does family use home remedies?

Who owns home?	Name:	Phone:	
	Address:		
When was the house built?			
What type of dwelling?	Single Family _____	School _____	Unknown _____
	Multi-Unit _____	Day Care _____	Other _____
What type of occupancy?	Owner Occupied _____	Public Housing _____	Unknown _____
	Private Rental _____	Section 8 _____	Other _____

NOTES: _____

Y=YES and N=NO (circle the one that applies)

Y or N	Does child crawl?
Y or N	Does child eat or chew on non-food items (paint chips, ashes, cigarette butts, batteries, paper, pencils/crayons)
Y or N	Does child eat dirt?
Y or N	Does child suck on batteries or other materials containing lead compounds? (lacquers, pipe sealants, putty, gasoline, oil, epoxy resin, dyes, etc...)
Y or N	Is there peeling paint inside or out or evidence of lead fallout on window sills, railings, porches, and outside steps or peeling paint on neighbors homes, garages or fences?
Y or N	Has residence been remodeled in the last six months?
Y or N	Does child have exposure to homemade or imported ceramic dishes?
Y or N	Does family store food in open cans and/or ceramic containers especially acid foods such as fruit juices, vinegars, homemade wines, etc...?
Y or N	Is dwelling located within two blocks of a freeway or major thoroughfare?

Y or N	Is dwelling located near a lead related industry?
Y or N	Is there peeling paint where child likes to play?
	Where, on the inside and outside of home, does child like to play?
	Where do you think child is getting lead exposures?
	How often does child get protein foods? (meat, eggs, peanut butter, beans, etc...)
	How often does child get calcium rich foods? (milk, cheese, green leafy vegetables)
	How often does your child get fruits and vegetables?
	How often does your child get breads and cereals?
	How often does your child get sweets and soft drinks?

REFERRALS

		Agency	Date
Was a referral made for developmental assessment?	Y or N		
Was a referral made for nutritional assessment?	Y or N		
Was a referral made to WIC?	Y or N		
Was a referral made to Head Start?	Y or N		

NOTES: _____

Please circle the specific event code(s) that occurred in this case and record the date:

Event Code	Event Description	Date Completed	Result Code
0CNTP	Contact Attempt by Phone		
0CNTL	Contact Attempt by Letter		
0IHVN	Initial Home Visit by P. H. Nurse		
0IHVC	Initial Home Visit by Case Manager		
0HVED	Home Visit for Lead Education		
0HVOT	Home Visit for Any Other Reason		
MDIEV	Medical, Initial Evaluation		
0MIRO	Referred for iron deficiency		
0MCHI	Chelation, Inpatient		
0MCHO	Chelation, Outpatient		
0RFRA	Referred to Licensed Risk Assessor		
0RACM	Received Risk Assessment report		
0HVRA	Risk Assessment Completed		
1FSTA	Environmental Investigation for the Indiana's 5-Star Environmental Recognition Program		
0HVDA	Developmental assessment conducted		
0DARF	Referral for developmental assessment		
0HDST	Headstart participant		

0HSRF	Referral for Headstart services		
0WICP	WIC participant		
0WICR	WIC referral		
0HVNA	Nutritional assessment conducted		
0NARF	Referral for nutritional assessment		
Remember to fill out the Environmental Questionnaire during visit			
Result Codes: C - Complete; L - Could Not Locate; M - Moved; N - No One Home; O - Incomplete, Other; R - Refused			

Completed By:

_____ Date

RETURN TO:
Indiana Lead and Healthy Homes Program
Environmental Public Health Division
Indiana State Department of Health
100 N. Senate Ave., N855
Indianapolis, IN 46204
317-233-1630 fax