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| **Patient Name:** | **DOB:** | | **LHD County:**  **Case Manager:** |
| **Patient Address:** | **City/Zip:** | | **Siblings under 6 years of age:** |
| **Parents/Guardian:**  **Phone:** | **Referred by PCP?**  Yes No **Date:** \_\_\_/\_\_\_/\_\_\_  **Name of PCP/Address/Phone:** | | |
| **Case Initiated:** \_\_\_/\_\_\_/\_\_\_ | **Case Closed:** \_\_\_/\_\_\_/\_\_\_ | | |
| **Closure Reason:**  BLL <3.5 μg/dL  Aged out  Moved out of state: Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_   Moved out of county: Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_  Lost to follow-up  Clinician closed case   Other (Describe) | | | |
| **Initial Test Date:** \_\_\_/\_\_\_/\_\_\_ BLL Result:\_\_\_\_\_\_\_  CapillaryVenous Collected at: | | | |
| **Confirmatory (Venous) Test Date:** \_\_\_/\_\_/\_\_\_ BLL Result:\_\_\_\_\_Venous Collected at: | | | |
| **Checklist: Confirmed BLL 3.5 µg/dL and higher:**   Provide pt./guardian with lead education (health effects and prevention).   Review possible lead sources and temporary measures to prevent the child from accessing potential sources.   Review diet and nutrition, focusing on iron and calcium intake. Dietary interventions include increasing vitamin C, calcium, and iron.   Review hand washing, play area, and house cleaning interventions.  **Child’s developmental milestones meet appropriate AAP guidelines:**  Yes  No \*If No, list missed milestones and/or delays: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Home Visit:** Date: \_\_/\_\_\_/\_\_\_ Attended by: \_\_\_\_\_\_\_\_\_\_\_\_  **WIC:** Referral Date: \_\_/\_\_\_\_ Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_   Currently Receives  Does Not Qualify  Declined  **Medical Nutritional Therapy:** Referred On: \_\_\_/\_\_\_/\_\_\_ Completed On: \_\_\_/\_\_\_/\_\_\_  Declined | | **Checklist: Additional Items**  Referred to Certified Risk Assessment for **BLL >15** µg/dL?  Yes  No  Referred On: \_\_\_/\_\_\_/\_\_\_  Date of Inspection: \_\_\_/\_\_\_/\_\_\_  Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred to PCP/Lead Specialist for **BLL >20 µg/dL?**   Yes  No  Date Referral Made: \_\_\_/\_\_\_/\_\_\_  Date of Visit: \_\_\_/\_\_\_/\_\_\_  Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Chelation Therapy (at the provider’s discretion)  Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Completed:\_\_\_/\_\_\_/\_\_\_  **Case Manager Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Patient Name:** | **DOB:** | **County:** | **Case Manager:** |

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| **Schedule for Follow-Up Blood Lead Testing** | | |
| **Venous BLLs**  (**µg/dL)** | **Early Follow-Up Tests**  **(2-4 tests after initial test above specific VENOUS BLLs)** | **Subsequent Follow-Up Tests**  **(after BLLs declining)** |
| ≥3.5–9 | 3 months \* | 6–9 months |
| 10–19 | 1–3 months\* | 3–6 months |
| 20–44 | 2 weeks–1 month | 1–3 months |
| ≥45 | As soon as possible | As soon as possible |

*\*Some case managers or healthcare providers may choose to repeat the blood lead test on all new patients within a month. Repeated testing helps to ensure that the BLL is not rising more quickly than expected.*

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| **Use BLL table below to document additional follow-up test results.** | | | |
| **Date** | **BLL Result** | **Capillary (C) or Venous (V)** | **Location** |
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| **Patient Name:** | | | **DOB:** | **County:** | **Case Manager:** |
| **Date** | **Report and track case notes, follow-up testing, communication, and other relevant activities.** | | | | |
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| **Patient Name:** | | **DOB:** | | **County:** | **Case Manager:** |
| **Date** | **Report and track case notes, follow-up testing, communication, and other relevant activities.** | | | | |
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