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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:** |
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