

Kentucky Childhood Lead Poisoning Prevention Program Home Visit Form (2020)

Case-managing nurse is responsible for faxing completed forms to (502)564-5766

Part 1: Home Visit Complete for all confirmed EBLs 5µg/dL and higher.

Patient Information: **Date of Investigation:** ___/___/___
 Health Department: _____ County FIPS: _____
 Name of Patient: _____ Birth Date: _____
 Address: _____
 Parent/Guardian Name: _____ Phone: _____
 Alternate Contact Person: _____ Phone: _____

Healthcare Provider:

- Provider Name: _____
- Provider Address: _____ Provider Phone: _____
- Is this the patient's medical home? Yes No
- Indicate any related medical treatment, including physician, hospital visits and chelation therapy.

Patient Testing and Results *Type: Capillary (C) or Venous (V)

Name	Date	Type*	Provider	Result
				µg/dl

Please complete for the patient's previous 12 months of housing:

Dates <small>mo/yr - mo/yr</small>	Address	Age of Dwelling	General condition of dwelling—including any remodeling/renovation, chipping/peeling paint:

How many people live in patient's household by age?

Children < 6 years? Number: _____ Children age 6 and over? Number: _____
 Adults ages 18-64? Number: _____ Adults age 65 and over? Number: _____

Does anyone in the home smoke? Yes No Do visitors smoke in home Yes No

Has anyone been diagnosed with Asthma that lives in the home? Yes No Ages:

Any Emergency room visits or hospitalizations for Asthma in the last year? Yes No

In the last 6 months, has any child had an injury/accident in the home that resulted in medical care?

Yes No Explain _____

Notes: _____

Patient Name: _____ DOB: _____

Child Behavior: Provide education based on responses.

Where does the child play outdoors?
Surface type in outdoor play area: <i>If bare soil, encourage parents to avoid bare soil as a play area. Rotate swing sets/toys as needed.</i>
Does the play area have any refuse, old automobiles or old buildings? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
What kinds of objects does the child put in their mouth?
Does child have a favorite ceramic, metal or painted cup or eating utensil? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Are any of the child's toys painted? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Does the child take baths in a porcelain bathtub that is chipping/peeling? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child regularly wear bracelets or necklaces (jewelry can contain lead)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, encourage controlled access to jewelry to avoid ingestion.</i>

Other Household Risk Factors: Provide education based on responses.

Does the family use any home remedies/herbal treatments/imported products? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Does the family use any imported cosmetics (such as kohl/kajal eyeliner or henna)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Does anyone in the family use hair dyes (some hair dye can contain lead acetate)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Does the family use any pottery to prepare or store food (some pottery/glazes can contain lead)? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Are any acidic liquids stored in metal, pewter or crystal containers? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Does the family use any imported canned items or products? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, describe:</i>
Are shoes removed at door before entering home and inaccessible to small children? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If no, explain the importance of keeping dust out of the home (mainly from occupational and hobby sources).</i>

Childcare Information:

Is the child cared for away from the home (daycare, family members, friends, church, etc.)? Yes No

If yes, describe:

Contact Name/ type of relation	Address	Hrs/week	General condition of structure

Patient Name: _____ DOB: _____

Additional potential sources identified:

Family Member Occupational Information:

- 1. Relationship: _____ Employer _____ Job Duties: _____
- 2. Relationship: _____ Employer _____ Job Duties: _____
- 3. Relationship: _____ Employer _____ Job Duties: _____
- 4. Relationship: _____ Employer _____ Job Duties: _____

Occupational & Hobby Exposures: Ask guardians about each activity.

Work	Hobbies	Potential Lead Exposures
		Remodeling, renovating or repairing homes or buildings
		Plumbing
		Using paint remover/chemical stripper
		Repairing/recycling radiators
		Melting metal for reuse (smelting) or pouring molten metal (foundry)
		Welding, burning, cutting, or torch work
		Auto body repair or auto mechanic work
		Working with batteries (making, salvaging or recycling)
		Making or splicing cable or wire
		Building, repairing, or painting ships/boats/trains
		Working with stained glass or at a glass factory
		Working at an oil refinery or a chemical plant
		Working at or visiting a firing range
		Making or reloading ammunition or explosives
		Making or using fishing sinkers
		Making paint or pigments/using artist paints
		Making or repairing jewelry
		Making, painting or glazing pottery

Other occupational or hobby exposures not listed:

Patient Name: _____ DOB: _____

Education to be covered with the parents/guardians: Check each section addressed. ✓

Review what lead is, where it can be found, why it is harmful and possible types of exposure for children (lead based paint in pre-1978 housing, occupational/hobby exposures, imported foods and goods etc.).	
Explain what an elevated blood lead level means and why it is especially harmful for small children.	
Explain the importance of monitoring blood lead levels to make sure interventions and education are working and detail expected follow-up testing recommendations (12 or 4-8 weeks).	
Address needed dietary changes (Calcium, Iron, Vitamin C rich foods) to help inhibit the absorption of lead in the body.	
Review prevention through handwashing : Encourage washing the child's hands frequently, before meals, after playing outside and before bed to prevent lead on the hands from being ingested.	
Explain house-cleaning techniques (damp dusting, non-abrasive cleaning of surfaces with lead based paint, eliminating friction surfaces etc.) for pre-1978 homes with deteriorating paint.	
Discuss restricting access to areas with chipping/peeling paint if applicable (blocking an area with furniture, placing the child in the center of the room on a blanket etc.).	
Discuss keeping the child's play area clean, wiping of the child's toys frequently to remove lead dust and placing their toys in a clean and covered tote.	
If the family has an occupational/hobby exposure to lead, discuss prevention techniques: changing clothes, shoes and hats at work when possible, keeping shoes outside and inaccessible to the child and other interventions that keep lead dust from entering the home and vehicles.	
If the family plans to perform renovations themselves, direct them to the EPA's guide to lead-safe renovations (can be found on EPA's website by searching renovate right).	
Explain that blood lead levels greater than or equal to 15µg/dL require a more in-depth investigation known as a risk assessment. This is where dust wipes, paint samples, soil samples and possibly water samples will be collected to determine the presence of lead.	

Educational information distributed:

Additional notes:

Signature of HV Staff: _____ **Date:** ___/___/___

Patient Name: _____ DOB: _____

Part 2: Property Information To be completed by the Environmentalist

Date of investigation: / /

Address:	
Estimated construction date:	
Is the home owned or rented?	Are there any subsidies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Subsidy: <input type="checkbox"/> Section 8 <input type="checkbox"/> Federal Rent Subsidy <input type="checkbox"/> Other	
<i>If other, describe:</i>	
Any renovations: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Move in date: / /
<i>If yes, describe:</i>	
Property owner name:	Phone:
Address:	
When the family took up residence at the home (own or rent) were they provided with any education on lead based paint? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Supplemental Address Use this section for additional addresses the child frequents.

Address:	
Estimated construction date:	
Is the home owned or rented?	Are there any subsidies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Subsidy: <input type="checkbox"/> Section 8 <input type="checkbox"/> Federal Rent Subsidy <input type="checkbox"/> Other	
<i>If other, describe:</i>	
Any renovations: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Move in date: / /
<i>If yes, describe:</i>	
Property owner name:	Phone:
Address:	

Basic Structural Information:

Basement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Attic? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Concrete foundation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Dirt floor in basement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any additions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Bedrooms:
Signs of water damage? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of Bathrooms:
Any major structural problems? (<i>Check all that apply</i>)	
<input type="checkbox"/> Large cracks <input type="checkbox"/> Holes in wall <input type="checkbox"/> Holes in floor <input type="checkbox"/> Holes in ceiling <input type="checkbox"/> Sagging floor <input type="checkbox"/> Sagging ceiling <input type="checkbox"/> Walls bowed <input type="checkbox"/> Walls out of plumb <input type="checkbox"/> None	
Is home clean and free of clutter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Is the home cleaned regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Source of drinking water:	Location of drinking water faucets?
Is the hot tap used to prepare food or drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>If yes, discourage using the hot tap for food/drinks to avoid ingesting lead particulate matter that can accumulate in hot water heaters.</i>	
Approximate distance of the home from the nearest street:	
Any lead industries near the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<i>If yes, describe:</i>	

Patient Name: _____ DOB: _____

Any nearby buildings or structures being renovated or demolished? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<i>If yes, describe:</i>
Any new plumbing/pipes in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Lead service pipe? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Any areas of bare soil? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Notes: _____

Visual Assessment Please mark any areas that have chipping or peeling paint with an x in the table below.

Exterior:

Room	Doors	Door Frame	Window	Window Frame	Walls	Base-board	Other Trim	Floor	Floor Type
Front Porch									
Back Porch									
Front of House									
Left Side									
Right Side									
Back of House									
Garage									
Outbuilding									

Interior:

Room	Doors	Door Frame	Window	Window Frame	Walls	Base-board	Other Trim	Floor	Floor Type
Living Room									
Kitchen									
Dining Room									
Den									
Study									
Bathroom 1									
Bathroom 2									
Bathroom 3									
Bedroom 1									
Bedroom 2									
Bedroom 3									
Bedroom 4									
Bedroom 5									
Enclosed Porch									
Basement									

Notes: _____

Environmental Signature _____ **Date:** ___/___/___

Patient Name: _____ DOB: _____

Part 3 (Optional): Healthy Homes Addendum

Use this section to assess safety of the home to connect the family to other programs at your health department.

Mold	(Y/N)		(Y/N)
Any visible mold?		Any musty odors anywhere in the home?	
Any signs of water damage that may be contributing to mold?		Is anyone experiencing asthma or allergy symptoms in any areas of the house?	

Fall and Choking Hazards:

Are blinds present?		Are cords secured out of child's reach?	
Any broken or missing stairs?		Are coverings on stairs firmly attached?	
Are stair railings present and secure?		If necessary, are stair gates present/functioning properly?	
Is stair lighting adequate?		Any other potential trip hazards?	

Smoke/Carbon Monoxide Hazards:

Is a smoke alarm present?		Is it operational?		Are batteries changed regularly?	
Is a carbon monoxide alarm present?		Is it operational?		Are batteries changed regularly?	
Is a fire extinguisher present?		Do homeowners know how to use the extinguisher?			
Does the home contain any unvented combustion appliances?		If so, which ones?			
Is a garage attached to the house?					

Electrical:

Any exposed wiring?		Any missing electrical outlet covers?	
Concerns about extension cords?		Are tamper-resistant outlet covers used in areas with young children?	

Pest Management:

Any evidence of cock roaches?		Any evidence of rodents?	
Any evidence of bed bugs?		Are exterior trash cans covered?	
Are there areas of standing water?		Any holes in the house that pests can enter through?	

Radon:

Has the home ever been tested for Radon?		If above 4, was the home mitigated?	
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Poisonings:

Can children reach storage areas for chemicals, pesticides, paints, cleaning supplies or medications?		Do these areas have a childproof lock?	
Are plants accessible to a child?		Is the family aware of the poison control hotline number?	

Referrals to Other Agencies:

Agency	Reason

Notes: _____

