**Medical Record Review**

**Agency:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reviewer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lead Case Manager :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Chart Code** | |  | | |  |  |  |  |  |  |
| **Date** **of Visit** | |  | | |  |  |  |  |  |  |
| **Reason for Visit:** *EPSDT blood lead screen or follow up* | |  | | |  |  |  |  |  |  |
| **Payor:** *Medicaid/MCO/Other* | |  | | |  |  |  |  |  |  |
| **Child’s medical home contacted in assuring blood lead test has not already been completed *Y/N*** | |  | | |  |  |  |  |  |  |
| **Age** **of Child** **at Visit** | |  | | |  |  |  |  |  |  |
| **BLOOD LEAD SCREENING of at-risk populations: *Children <72 months of age and prenatal patients who are Medicaid enrolled, living in a high-risk zip code area or having positive or don’t know response to any question on the lead poisoning verbal risk assessment.*** | | | | | | | | | | | | |
| ***MEDICAID ENROLLED*** | | | | | | | | | | | | |
|  | | **Blood Lead Screening of Medicaid enrolled *Children <72 months of age and prenatal patients*** | |  | | |  |  |  |  |  |  |
| ***HIGH RISK ZIP CODE AREA*** | | | | | | | | | | | | |
|  | | **Child Living in High Risk Zip Code Area:** *Yes/No* | |  | | |  |  |  |  |  |  |
|  | | **# of ↑ High Risk Zips in County** | |  | | |  |  |  |  |  |  |
| ***LEAD POISONING VERBAL RISK ASSESSMENT TOOL*** | | | | | | | | | | | | |
|  | | **Use of LEAD** Poisoning Verbal Risk Assessment- starting @ *6 mo* | |  | | |  |  |  |  |  |  |
| **Documentation** *of lead risk assessment completion,+ responses & Action taken q visit* | |  | | |  |  |  |  |  |  |
| **Child has + Pb Risk/Hazards** | |  | | |  |  |  |  |  |  |
| **Blood Pb Testing** for ‘positive or unknown’ responses | |  | | |  |  |  |  |  |  |
| ***LEAD POISONING PREVENTIVE EDUCATION/ ANTICIPATORY GUIDANCE*** | | | | | | | | | | | | |
|  | | **Preventive Lead Anticipatory Guidance *provided at each age appropriate pediatric preventive and initial prenatal visit*:** *Handout, phamphlets given and* ***REVIEWED*** | |  | | |  |  |  |  |  |  |
| ***BLOOD LEAD RESULTS(documented in medical record)*** | | | | | | | | | | | | |
|  | | **Blood lead collection date** *(date)* | |  | | |  |  |  |  |  |  |
|  | | **Blood lead results received by LHD** *(date)* | |  | | |  |  |  |  |  |  |
|  | | **Blood Lead Results** *(ug/dL)* | | *ug/dL* | | | *ug/dL* | *ug/dL* | *ug/dL* | *ug/dL* | *ug/dL* | *ug/dL* |
|  | | **Specimen type and site collected in medical record (MR)** | |  | | |  |  |  |  |  |  |
|  | | **Blood lead result signed off by R.N. and placed in MR** *(date)* | |  | | |  |  |  |  |  |  |
|  | | **All non-venous EBLL results confirmed** *in timeframe indicated in CCSG* | |  | | |  |  |  |  |  |  |
|  | | **EBLL’s referred to LHD Lead CM upon receipt** (date) | |  | | |  |  |  |  |  |  |
|  | | **EBLL reported to LHD within 7 days from collection date?** | |  | | |  |  |  |  |  |  |
| ***EBLL FOLLOW-UP INTERVENTION*** | | | | | | | | | | | | |
|  | | | **Parent notice of abnormal BLL:** *telephone (T)/letter(L):* |  | |  | |  |  |  |  |  |
| **Follow up interventions** *integrated w/other LHD visits* |  | |  | |  |  |  |  |  |
| **If not venous** | | | **EBLL CONFIRMED** within appropriate timeframe |  | |  | |  |  |  |  |  |
|  | | | **Confirmed Cases:**  **Lead CM forms should be complete with**   * *Pt. Demograghics;* * *Actions/Interventions all;* * *Dated and Initialed* |  | |  | |  |  |  |  |  |
| ***Environmental*** | | | | | | | | | | | | |
| Part I | | | **Visual Investigative Home Visit**-Part I completed by RN. |  | |  | |  |  |  |  |  |
| Part II | | | **Visual Investigative Home Visit-**Part II completed by RS. |  | |  | |  |  |  |  |  |
| ***Nutrition*** | | | | | | | | | | | | |
| WIC | | | **WIC: Currently on or Refer to** |  | |  | |  |  |  |  |  |
| MNT | | | **MNT:** *referred & visit for ↑ lead* |  | |  | |  |  |  |  |  |
| ***LEAD POISONING >15 ug/dL*** | | | | | | | | | | | | |
|  | **Referred to PCP for Medical Evaluation and F/U** | | | |  |  | |  |  |  |  |  |
| **Referred to Certified Risk Assessor** within 2 weeks for lead inspection with samples Y/N | | | |  |  | |  |  |  |  |  |
| **Lead Inspections completed within 30 days of referral Y/N** | | | |  |  | |  |  |  |  |  |
| **FOR BLL’s >25** µg/dL; provide PCP with Lead Specialist contact information | | | |  |  | |  |  |  |  |  |
| **Original CM form in MR** | | | |  |  | |  |  |  |  |  |
| **Case Closed according to CCSG/AR: Final report** *faxed to DPH Nurse Consultant Inspector* | | | |  |  | |  |  |  |  |  |
| **Tracking Method:** *tickler* | | | |  |  | |  |  |  |  |  |
|  | **RTC:** *appt given* | | | |  |  | |  |  |  |  |  |
|  | **Correct labels on all items reviewed** | | | |  |  | |  |  |  |  |  |
|  | **Other**- specify | | | |  |  | |  |  |  |  |  |
| **COMMENTS** |  | | | |  |  | |  |  |  |  |  |