**Medical Record Review**

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

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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** |  |  |  |  |  |  |  |  |