Kentucky Childhood Lead Poisoning Prevention Program
Case Manager Form (2022)

Fax to (502) 564-5766 Attn: KYCLPPP

County:	**Date:**	**Patient Name:**	**DOB:**
Case Manager:		**Siblings under 6 years of age:**	
LHD Case Initiated: / /	**Case Closed: / /**	**Referred by PCP?** ☐ Yes ☐ No **Date: / /**	

Closure ☐ Lost to follow-up ☐ BLL below 3.5 µg/dL for 6 months (needed for levels 15 and higher) ☐ BLL below 5µg/dL
Reason: ☐ Child aged out ☐ Child moved out of county to: _____ ☐ Child moved out of state to: _____
☐ Other (Describe)

Patient Address:	**City/Zip**	**Parents/Guardian:**	**Phone:**

Initial Test Date: ____/___/___ BLL Result: _____ ☐ Cap ☐ Ven Test Location: _____	**Confirmatory Test Date:** ___/___/___ BLL Result: _____ ☐ Ven Test Location: _____	**Early Follow-up Testing:** ☐ Every 3 months (levels between 3.5-9 µg/dL) ☐ Every 1 - 3 months (levels 10-19 µg/dL) ☐ Every 2 weeks – 1 month (levels 20-44 µg/dL) ☐ As soon as possible (levels ≥45 µg/dL) ☐ Other, please describe: _____

Checklist: Confirmed BLL 3.5 µg/dL and higher:

☐ Provide pt./guardian with lead education (health effects and prevention).
☐ Review possible sources of lead and temporary measures to prevent child from accessing potential sources.
☐ Review diet and nutrition with a focus on iron and calcium intake. Dietary interventions include an increase in vitamin C, calcium, and iron.
☐ Review hand washing, play area, and house cleaning interventions.
☐ Child's developmental milestones meet appropriate AAP guidelines.
Home Visit Done. Date___/____/____ Attended by: _____
☐ **Medical Nutrition Therapy Referral**
Referred On: ____/____/_____ Completed: _____/_____/____

☐ **WIC Referral.** ☐ Currently receives ☐ Does not qualify
Referred On: ____/____/_____ Completed: _____/_____/____

Checklist: Additional Items

☐ **Referred** to Certified Risk Assessment for **BLL ≥15 µg/dL**
Referred On: ____/____/_____ Completed: _____/_____/____
Completed By: _____

☐ **Referred** to primary care provider/lead specialist for **BLL ≥20 µg/dL**
Referred On: _____/_____/____ Completed: _____/_____/____
Provider: _____

☐ Chelation Therapy (at provider's discretion)
Provider: _____ Completed: _____/_____/____

Patient Name: **DOB:**

County:

Case Manager:

Use this form to report and track case notes, follow-up testing, communication, and other relevant activities.

Date:	

Notes:

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