State of Illinois
Illinois Department of Public Health

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Public Health Home Visit Form for Environmental Health and Lead Assessment

Date_____

Child's name _____
Last First MI

D.O.B._____ Male _____ Female_____

Ethnicity _____

Medicaid number _____

Parent's/Guardian's name_____

Phone _____

Alternate phone_____

Street address _____ Apt. _____

City_____ ZIP_____ County_____

How long at this address? Years _____ Months _____

Previous address _____

_____

❑ Rent ❑ Own

Landlord's address _____

_____

Landlord's phone_____

Does the child spend time at:

❑ Daycare ❑ Head Start ❑ Preschool

❑ Babysitter ❑ Relative/Friend ❑ Other

List addresses for checked box(es)

Name, address, phone _____

_____ Time spent _____

Name, address, phone _____

_____ Time spent _____

Physician's name _____

Physician's address _____

Physician's phone number _____

Test date _____ BLL result _____ µg/dL

Test method _____ venous _____ capillary

A. FAMILY ASSESSMENT

1. Number of children in household _____

Name DOB Relationship Lead Tests

_____

_____

_____

_____

_____

2. Parent's occupations/hobbies _____

_____

3. Are there any pregnant women in the household?
❑ yes ❑ no

   a. Have the pregnant women been tested for lead?
   ❑ yes ❑ no
   Results _____ Reason for testing
   _____

   b. Has educational material been given to pregnant women? ❑ yes ❑ no

   c. Occupation _____
   Hobby _____

4. What does the parent/guardian think may be the source of the lead poisoning?
_____

B. CHILD'S HEALTH STATUS AND HISTORY

C. REVIEW OF SYMPTOMS

Symptoms	Initial Visit Date	Follow-up Date
Abdominal pain		
Constipation		
Vomiting		
Extreme activity		
Excessive tiredness		
Irritability		
Other		

D. DEVELOPMENTAL DELAYS

Gross motor	
Fine motor	
Previous testing/ evaluation	
Social skills	
Speech	

E. ORAL TENDENCIES

1. Has the child been observed mouthing or eating non-food substances? ❑ yes ❑ no
2. What does the child put in his/her mouth?
❑ Hands ❑ Toys ❑ Windowsills ❑ Magazines
❑ Newspapers ❑ Railings/Moldings ❑ Doors
❑ Furniture ❑ Dirt ❑ Other _____
3. How often does the child put his/her hands or other objects in his/her mouth?
❑ Never/Rarely ❑ Sometimes ❑ Often/Frequently
4. Is the child a thumb/finger sucker/nail biter? ❑ yes ❑ no
5. Does the child use a pacifier? ❑ yes ❑ no

F. SLEEPING AREAS

1. Is there loose paint on nearby walls or the ceiling that could fall into the child's bed? ❑ yes ❑ no
2. Does the crib, furniture or windowsills show teeth marks? ❑ yes ❑ no
3. Is the child's bed near a window exposed to inside/outside sources of lead? ❑ yes ❑ no

G. FOOD PREPARATION AND EATING AREA

1. Is any paint peeling from ceilings or walls in the food preparation or eating areas? ❑ yes ❑ no
2. Are there any windows or doors in the food preparation area that could create lead dust? ❑ yes ❑ no
3. Do you use hot tap water when preparing food or bottles? ❑ yes ❑ no
4. Do you prepare or store food in or eat food from cans or pottery? ❑ yes ❑ no
5. Do you use glazed dishes or dishes made in a foreign country? ❑ yes ❑ no

H. EATING HABITS

1. Is your child enrolled in the Women, Infants, Children (WIC Program)? ❑ yes ❑ no
2. How many meals and snacks per day does your child eat?
_____
At what times? _____

H. EATING HABITS (cont.)

3. How many servings of fruit and vegetables does your child eat per day?_____
4. How many servings per day does your child eat meat/eggs/dried beans? _____
5. How many ounces of milk/yogurt/cheese does your child drink or eat per day? _____
6. Does your child use a bottle? ❑ yes ❑ no
7. Do you use bottled water to prepare formula or other drinks for your child? ❑ yes ❑ no
8. Does the bottled water include fluoride? ❑ yes ❑ no
9. Does your child take a vitamin with iron or other supplements every day? ❑ yes ❑ no
10. Do you have any food, candy or supplements that were packaged in another country? ❑ yes ❑ no

I. PLAY HABITS AND ENVIRONMENTAL SAFETY

1. Does your child hide and play quietly? ❑ yes ❑ no
If yes, where? _____
2. Where else inside the house does your child play?
_____
3. Where does your child play outside?
_____
4. Does your child play in the basement? ❑ yes ❑ no
5. Does your child play on the porch? ❑ yes ❑ no
6. Has anyone in the home been diagnosed with asthma? ❑ yes ❑ no
7. Does anyone in the home have asthma now? ❑ yes ❑ no
8. Do you have pets? ❑ yes ❑ no
9. Does anyone smoke in the house? ❑ yes ❑ no
10. Is there a garage/outbuilding on the property? ❑ yes ❑ no

I. PLAY HABITS AND ENVIRONMENTAL SAFETY (cont.)

11. Are there mini-blinds in the sleep or play area?
❑ yes ❑ no

12. Are the cords on the mini-blinds out of reach of the child?
❑ yes ❑ no

13. Does your child play at the window? ❑ yes ❑ no

14. Does your child play with painted or metal toys, antique toys or toy jewelry? ❑ yes ❑ no

15. Do you keep all firearms in a locked gun safe?
❑ yes ❑ no

16. Do you utilize safety gates to prevent a child from entering a stairwell or other area that might present a danger to the child? ❑ yes ❑ no

17. Do you have operational CO detectors? ❑ yes ❑ no
Do you have operational smoke alarms? ❑ yes ❑ no
Do you have an operational fire extinguisher?
❑ yes ❑ no

18. Do you use safety products, i.e., child bathtub chairs and gates at swimming pools and other areas to prevent accidental drowning? ❑ yes ❑ no

19. Do you use indoor pesticides? ❑ yes ❑ no

20. Are you aware of any water problems or mold conditions?
❑ yes ❑ no

J. OBSERVATION OF DWELLING UNIT

1. Exterior construction:
❑ Painted ❑ Brick ❑ Other_____

2. Is paint peeling or chipping from walls or ceiling?
❑ yes ❑ no
If so, where?_____

3. Is the house in a high traffic area or near an industry (i.e., foundry, lead smelter, battery recycling facility)?
❑ yes ❑ no

4. Are renovations occurring? ❑ yes ❑ no

5. Housekeeping practices ❑ Good ❑ Moderate ❑ Poor

6. Overall condition of the house?
❑ Good ❑ Moderate ❑ Poor

7. Age of windows _____

8. Has your home been tested for radon? ❑ yes ❑ no

9. Are you interested in information on how to obtain a test kit?
❑ yes ❑ no

COMMENTS

_____
Staff conducting home visit

_____
Case manager

_____
Nurse signature

_____
Today's date

_____
Date of environmental investigation referral

Care Plan/Assessment

Nursing Diagnosis: Elevated blood lead level as evidenced by confirmatory level of _____

Goal: The family will have an improved understanding of elevated blood lead levels and will carry out practices that will minimize lead exposure. The child will have decreased blood lead levels and will demonstrate optimal growth and development.

Intervention:			**Date**
1. Discuss possible sources of lead exposure (paint, occupation, cultural). Identify, if possible, the lead source.	Yes	No	
2. Conduct “visual assessment” of the child’s environment.	Yes	No	
3. Discuss effects of elevated blood lead levels (IQ/behavior/growth).	Yes	No	
4. Review behaviors that put child at risk for lead exposure (hand mouth).	Yes	No	
5. Review housekeeping, cleaning, remodeling, hygiene.	Yes	No	
6. Discuss nutrition (iron, vitamin c, calcium, 3 meals, 3 snacks).	Yes	No	
7. Refer for environmental inspection, document referral.	Yes	No	
8. Explain need for follow-up testing.	Yes	No	
9. Refer or conduct developmental screening.	Yes	No	
10. Referrals to social service agencies/programs (WIC, Medicaid, FS).	Yes	No	
11. Physician contact.	Yes	No	
12. Provide educational materials.	Yes	No	
13. Offer radon information and access to testing kits.	Yes	No	
14. Offer indoor clean air quality education.	Yes	No	

Nurse signature_____ Date _____

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