

# EPIDEMIOLOGICAL INVESTIGATION FORM

Questionnaire for Investigation of Children with Elevated Blood Lead Levels

## Environmental Investigation – General Information

<b>Date of Investigation:</b> ____ / ____ / ____		<b>Investigator's Name:</b>		<b>Health Department/District:</b>	
<b>Start Time of Interview:</b> _____			<b>Interview Conducted:</b> <input type="checkbox"/> In Person <input type="checkbox"/> Over Phone		
<b>End Time of Interview:</b> _____			<b>Was the child present during interview</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Name of Person Interviewed:</b>			<b>Relationship to Child:</b>		
<b>Address of Dwelling:</b> (Include Unit or Apt #)					
<b>Is address in a high-risk area (i.e. Pre-1950 neighborhood of a city or older mill row housing in a rural town)?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Approximately what year was this dwelling built? _____.					
<b>Dwelling Type</b>		Single family <input type="checkbox"/> Multi-unit <input type="checkbox"/> Unknown <input type="checkbox"/> <input type="checkbox"/> Other: _____			
<b>Ownership Information</b>		If unknown, was the dwelling built before 1978? Yes <input type="checkbox"/> No <input type="checkbox"/> If rental, is there any rent subsidy? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what type of subsidy? Public Housing <input type="checkbox"/> Section 8 <input type="checkbox"/> State Rental Assistance Program <input type="checkbox"/> Other <input type="checkbox"/>			
<b>Rental Landlord Information</b>		Name of Landlord: _____ Address: _____ Phone: _____			

## Child – General Information

<b>1<sup>st</sup> Child's Name</b> (First, Middle, Last): _____	
Date of Birth: ____ / ____ / ____	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
Is this child currently enrolled in or attending any Special Education program or classes? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>2<sup>nd</sup> Child's Name</b> (First, Middle, Last): _____	
Date of Birth: ____ / ____ / ____	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
Is this child currently enrolled in or attending any Special Education program or classes? Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>3<sup>rd</sup> Child's Name</b> (First, Middle, Last): _____	
Date of Birth: ____ / ____ / ____	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/>	
Is this child currently enrolled in or attending any Special Education program or classes? Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>Race</b>	American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>
<b>Ethnicity</b>	Hispanic <input type="checkbox"/> non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/>
<b>Child(ren)'s Current Address</b>	(If different than address under investigation)
<b>Parent/Guardian Information</b>	Mother's Name: _____ Current Address: _____ Telephone #: _____ (home) _____ (cell) Spoken Language: _____ Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>
	Father's Name: _____ Current Address: _____ Spoken Language: _____ Hispanic: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>

#### Other Child Living in Dwelling Unit – General Information

**Complete the following table for all other children ≤ 15 years of age living in the dwelling unit under investigation.**

Child's Name	Date of Birth	Gender	Most Recent Venous Blood Test & Level	Has this child ever had lead poisoning (≥ 5 µg/dL)?

Follow-up – If other children are living in the dwelling and have not had an acceptable screening or venous blood lead test, request that they get tested as soon as possible.

#### Child(ren)'s Medical Provider and Insurance Information

Clinic/Agency/PCP Providing Lead Testing	Name of Provider/Primary Care Physician (PCP): _____
	Address: _____
	Phone #: _____
Insurance Carrier	Name of Carrier: _____ Is child a Medicaid Recipient: Yes <input type="checkbox"/> No <input type="checkbox"/>
What advice or education materials did the <b>PCP</b> provide to the parents or guardians? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Was information received in a language that the parents or guardians could read?

Yes  No

### Child Medical Status

#### Chelation Status for All Children Identified

Is the child(ren) currently being chelated?

1<sup>st</sup> child Yes  No   
2<sup>nd</sup> child Yes  No   
3<sup>rd</sup> child Yes  No

If no, skip to Testing Status below

If yes\*, is the chelation being done as an in-patient or out-patient?

In-patient  Out-patient

\*Be sure to complete adjacent column

#### In-Patient

a) Date of scheduled discharge? \_\_\_ / \_\_\_ / \_\_\_

b) Where will child(ren) go after discharge?  
\_\_\_\_\_

c) What steps were taken to determine if this location is lead-safe?  
\_\_\_\_\_

d) Lead hazards must be assessed and assurance provided that adequate interim control measures will be implemented **prior** to child's discharge. Has this occurred? Yes  No

#### Out-Patient

a) Where is the child(ren) residing during treatment (address)?  
\_\_\_\_\_

b) What steps were taken to determine is this location is lead-safe?  
\_\_\_\_\_

c) Lead hazards must be assessed and assurance provided that adequate interim control measures will be implemented **prior** to child's discharge. Has this occurred? Yes  No

**\*If no, treatment cannot begin. Temporary relocation to a lead-safe environment will be necessary – discuss with Regional Lead Treatment Center**

#### Testing Status

1) When is the child(ren)'s next appointment for a blood test?

1<sup>st</sup> child: \_\_\_ / \_\_\_ / \_\_\_ 2<sup>nd</sup> child: \_\_\_ / \_\_\_ / \_\_\_ 3<sup>rd</sup> child: \_\_\_ / \_\_\_ / \_\_\_

*Provide guidance as to when the child should be retested if parent/guardian is unsure*

Follow-up Testing Schedule for Children with a <b>Confirmed (venous) blood lead level</b>	
Less than 3.5 µg/dL	Follow-up testing is not required
3.5 to 9.9 µg/dL	3 months
10 to 19.9 µg/dL	1 to 3 months
20 to 44.9 µg/dL	2 weeks to 1 month
Greater than or equal to 45 µg/dL	As soon as possible

2) If Health Care Provider did not recommend diagnostic retest:

- Educate provide on CT lead screening requirements. Date: \_\_\_\_\_
- Inform the health care provider that the American Academy of Pediatrics "Standards of Care" follows the CT lead screening requirements.

#### Symptoms Reported in

Loss of appetite       Vomiting       Diarrhea       Weight Loss  
 Constipation       Irritability       Sudden behavior change

<b>Child(ren)</b>	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Headache	<input type="checkbox"/> Tiredness
	<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Staggering gait (unbalanced)	<input type="checkbox"/> Seizures or convulsions
	<input type="checkbox"/> Poor coordination	<input type="checkbox"/> Muscle weakness	
	<input type="checkbox"/> Other: _____		
	<input type="checkbox"/> None of the above		

**Residency Information and History**

1) Where do you think your child(ren) has been exposed to a lead hazard?

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2) When did you/your family move into your current home?

Complete the following for each address where the child has lived **during the past 12 months:**

Dates of Residency	Address (include city and state)	Approx. age of dwelling	General condition of dwelling: Any deteriorated pain? Any remodeling or renovations?

3) Is the child(ren) cared for at locations *other* than the home (including preschool, child care center, family child care home or care provided by a relative or friend)?

Yes  No

If yes, complete the following:

Type of Care	Name of contact, address, and phone #	Approx. # of hours per week	General condition of dwelling: Any deteriorated pain? Any remodeling or renovations?

4) Does the State or Local Health Department have any records of previous cases of children with elevated levels of lead in their blood, for the child's primary addresses?

Yes  No  If yes, specify: \_\_\_\_\_

**Child Behavior**

	1 <sup>st</sup> child		2 <sup>nd</sup> child		3 <sup>rd</sup> child	
	Yes	No	Yes	No	Yes	No
1) Does the child suck his or her fingers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Does the child put painted objects into their mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
3) Does the child chew on painted surfaces, such as old painted cribs, windowsills, furniture edges, railings, door moldings, or broom handles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
4) Does the child chew on glazing compound from windows?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Does the child put soft metal objects into their mouth (e.g., lead and pewter toys, jewelry, gunshot or bullets, beads, fishing sinkers, keys, telephone cords, or any item containing solder [electronics])?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
6) Does the child chew or eat paint chips or pick at painted surfaces?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the paint intact in the child's play areas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Does the child put printer materials (newspaper, magazines) in their mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
8) Does the child play with cosmetics, hair preparations, or talcum powder or do they put them into their mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are any of these products foreign made?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Does the child have a favorite cup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have a favorite eating utensil?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are they handmade or ceramic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Does the family burn candles with metal wicks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) Does the family have a dog, cat or other pet that could track contaminated soil or dust from the outside?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) If child(ren) are present during the interview or investigation, note extent of hand-to-mouth behavior observed	_____ _____ _____					
<b>Assessment &amp; Actions:</b>						
Is child at risk due to hand-to-mouth behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is child at risk for mouthing probably lead-containing substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
Is the child at risk for other hazards?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____						
Was the family counseled to limit access to probably hazards or eliminate use of possible hazardous items as noted above? Yes <input type="checkbox"/> No <input type="checkbox"/> if yes, specify: _____						
Other (specify): _____						

### Lead-Based Paint and Lead Dust Hazards

1) Has there been any recent (past six months) repainted, remodeling, renovation, lead abatement, window replacement, sanding, or scraping of painted surfaces inside or outside this dwelling unit? Yes  No

If yes, please provide dates and describe activities and duration of work in more detail: \_\_\_\_\_

2) Has this dwelling been previously tested for lead-based paint or lead-contaminated dust? Yes  No

If yes, when? \_\_\_\_\_

If no, skip to question 4

3) If previously tested for lead contaminated dust, did dust levels exceed standards? Yes  No

If yes, where were hazards located? \_\_\_\_\_

Were dust hazards corrected? Yes  No

If yes, when? \_\_\_\_\_

4) Where does the child(ren) like to play, hide, or spend a lot of time? Include rooms, closets, porches.

Area where child(ren) like to play, hide, or spend a lot of time?	Paint condition (intact, deteriorated, or not present) *	Location of any painted components with visible bite marks

\* **Paint Condition** – note location and extent of any visible chips and/or dust in window wells, on window sills, or on the floor directly beneath windows. Do you see peeling, chipping, chalking, flaking or deteriorated paint? If yes, note location and extent of deterioration.

**Assessment & Actions:**

Possible lead-based paint hazards? Yes  No

If yes, specify:

Possible lead dust hazards? Yes  No

If yes, specify where: \_\_\_\_\_

If possible, obtain records of previous environmental testing noted above (C.2) Yes  No

If no, specify why: \_\_\_\_\_

### Water Lead Hazards

1) What is or are the source(s) of drinking water for the family?

Public Water Supply  Private Well  Bottled water

2) From which faucet(s) does they family use to obtain drinking water or water for cooling or food preparation?

3) Does the family use the water immediately or do they let the water run for a while first? \_\_\_\_\_

4) Is tap water used to prepare infant formula, powdered milk or juices for the child(ren)? Yes  No

If yes, does the family use hot or cold tap water? \_\_\_\_\_

If not, from what source(s) does the family obtain water for child(ren)? \_\_\_\_\_

5) Has new plumbing been installed within the last 5 years? Yes  No

If yes, identify location(s): \_\_\_\_\_

Did the parent/guardian do any of the work themselves? Yes  No

If yes, specify: \_\_\_\_\_

6) Has the water ever been tested for lead? Yes  No

If yes, where can test results be obtained: \_\_\_\_\_

#### Assessment & Actions:

Is the child at risk for water lead hazards? Yes  No

#### **Water test required (first draw and flush samples).**

Location and date sample taken: \_\_\_\_\_

Counseled family on methods to reduce possible lead in water exposure. Date: \_\_\_\_\_

Specify: \_\_\_\_\_

Lead in Soil Hazards

1) Where outside does the child(ren) like to play, hide, frequent? \_\_\_\_\_

2) Is there deteriorated paint on any exterior structures or component (ex. fences, porches, garages)? Yes  No   
If yes, note location. \_\_\_\_\_

3) Are there visible paint chips near the perimeter of the house, fences, garage and play structures? Yes  No   
If yes, note location. \_\_\_\_\_

4) Is this dwelling located near a lead-producing industry (battery plant, smelter, radiator repair shop, or electronics)?  
Yes  No   
If yes, specify. \_\_\_\_\_

5) Is the dwelling located within 2 blocks of a major roadway, freeway, or highway? Yes  No   
If yes, specify. \_\_\_\_\_

6) Are nearby buildings or structures being renovated, repaired or demolished? Yes  No   
If yes, note location and activity. \_\_\_\_\_

7) Was gasoline or other solvents ever used to clean parts or disposed of on the property?  
Yes  No  Unknown

8) Has soil ever been tested for lead? Yes  No   
If yes, where can this information be obtained? \_\_\_\_\_

9) Have you burned painted wood in a woodstove or fireplace? Yes  No   
If yes, have you emptied ashes onto soil? Yes  No   
If yes, where? \_\_\_\_\_

Assessment & Actions:

Possible soil lead hazards. Yes  No

Exposed (**bare**) soil areas must be tested (especially at dripline and play areas) Yes  No

Have samples have been collected Yes  No   
If not, specify why. \_\_\_\_\_

Counseled family to keep child away from bare soil areas thought to be a risk.  
Yes  No  Date: \_\_\_\_\_



**Other Household Risk Factors**

1) Are imported cosmetics such as Kohl, Surma, Henna, or Ceruse used in the home? Yes  No

If yes, list type(s): \_\_\_\_\_

2) Does the family ever use any home remedies or herbal treatments such as Azarcon, Litargirio, Bebetina, Pay-loo-ah, Chyawan Prash, Kohl or Greta? Yes  No

If yes, what type: \_\_\_\_\_

3) Has the child(ren) played with or has the family purchased or received as a gift any toys, jewelry, etc. that have been recalled by the Consumer Protection Safety Commission (CPSC) as containing lead? Yes  No

<https://www.cpsc.gov/> (English)

<https://www.cpsc.gov/es/SeguridadConsumidor> (Spanish)

4) Are any beverages or liquid food products stored in metal, pewter, or crystal containers? Yes  No

If yes, what type: \_\_\_\_\_

5) What containers are used to prepare, serve and store the child's food? \_\_\_\_\_

Are any of them metal, soldered or glazed? Yes  No

Does the family cook with or utilize ceramic-products or pottery? Yes  No

If yes, specify: \_\_\_\_\_

6) Does the family use imported food items regularly? Yes  No

If yes, specify: \_\_\_\_\_

7) Does the child play in, live in, or have access to any areas where the following materials are kept: shellac, lacquers, dyes, coloring pigments, epoxy resins, pipe sealants, putty dyes, industrial crayons or markers, gasoline, paints, pesticides, fungicides, gear oil, detergents, old households or motor vehicle batteries, battery casings, fishing sinkers, lead pellets, solder, or drapery weights? Yes  No

**Assessment & Actions:**

Possible increased risk of lead exposure due to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Counseled family about products that may be potential sources of lead exposure (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specify other actions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current Housekeeping Practices

1) What cleaning equipment does the family have in the dwelling?

- Mop and bucket
- Vacuum **with no HEPA filter**
- Vacuum **with a HEPA filter**
- Broom
- Sponges and rags
- Other: \_\_\_\_\_

2) How often does the family clean?

- Sweep the floors? \_\_\_\_\_
- Wet mop the floors? \_\_\_\_\_
- Vacuum the floors? \_\_\_\_\_
- Wash the window troughs? \_\_\_\_\_

3) Are the floor coverings smooth and/or cleanable? Yes  No

What type of floor coverings are found in the dwelling? (*Check all that apply*)

- Vinyl/linoleum
- Carpeting
- Wood
- Other (specify): \_\_\_\_\_

4) Cleanliness of dwelling:

Circle the overall status of cleanliness (A, B, C) based on observations of cleanliness in the dwelling and fill out assessment and actions.

A. Appears clean.

No visible dust on most surfaces  
No debris or food particles scattered about  
Few visible cobwebs

No matted or soiled carpeting  
Evidence of recent vacuuming of carpet  
Clean door jambs

B. Some evidence of housekeeping.

Slight dust buildup in corners  
Some debris or food particles scattered about  
Slight dust buildup on furniture  
Slightly soiled kitchen floor

Slightly matted and/or soiled carpeting  
Slightly soiled door jambs  
Some visible cobwebs

C. No evidence of housekeeping.

Heavy dust buildup in corners  
Debris or food particles scattered about  
Heavy dust buildup on furniture  
Heavily soiled kitchen floor

Matted and/or soiled carpeting  
Heavily soiled door jambs  
Visible cobwebs

#### Assessment & Actions:

Is cleaning equipment adequate? Yes  No

Are floor coverings adequate to maintain clean environment? Yes  No

Counseled parents on the role of adequate housekeeping in reducing lead exposures. Yes  No

Provided counseling on what cleaning equipment is needed Yes  No

If yes, specify: \_\_\_\_\_

Instructed family on special cleaning methods. Yes  No

If yes, specify: \_\_\_\_\_

Flooring treatments needed. Yes  No

If yes, specify: \_\_\_\_\_

### Occupational, "Do-It-Yourself", Hobby Lead Hazards

Use the information in this section to determine if the child(ren)'s source of lead exposure could be related to the parents', older siblings' or other adults' work environment, "do-it-yourself" activities, or to activities related to hobbies. Occupations, hobbies, and work activities that may cause lead exposure include the following: **list the name, relationship to the child(ren), and location of activity**

Household Member's Occupations	Occupation (O) & Location	Hobby (H) & Location
Adult 1:		
Adult 2:		
Adult 3:		
Adult 4:		
Adult 5:		

Activity	Adult 1	Adult 2	Adult 3	Adult 4	Adult 5
Ammunition manufacturing and reloading	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Auto body repair work	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Boat or ship building, repairing or painting	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Cable or wire splicing or salvaging	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Chemical plant, glass factory or oil refinery	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Electrical soldering, radio repair, or other equipment repair	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Firing range	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Fishing or hunting	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Jewelry repair or production	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Lead abatement worker or supervisor	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Metal melting for reuse (smelting) or molten metal pouring (foundry)	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Paint removal, chemical stripping and/or repainting of buildings or structures	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Plumbing	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Pottery making	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Radiator repair	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H

Remodeling, repairing, renovating or demolition of residential and/or commercial buildings or structures	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Salvaging metal or batteries	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Stained glass repairing or productions	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H
Welding, burning, cutting or torch work	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H	<input type="checkbox"/> O <input type="checkbox"/> H

- 1) Are work clothes left at work? Yes  No   
 Are work clothes washed separately from other laundry? Yes  No
- 2) Is the family vehicle used for work activities? Yes  No
- 3) Is there evidence of take-home work exposures or hobby exposure(s) in the dwelling? Yes  No

**Assessment & Actions:**

Possible occupational related lead exposure. Yes  No

*If yes, have you recommended blood lead testing?* Yes  No

Possible hobby related lead exposure. Yes  No

*If yes, have you recommended they stop suspected hobby?* Yes  No

*Counseled family on limiting occupational and/or hobby exposures.* Yes  No

*If yes, specify:* \_\_\_\_\_

**Educational Material**

1) Did parent or guardian receive the standard educational packet from the local health department?

Yes  No

If not, why? \_\_\_\_\_

2) Is the educational materials in a language the parent or guardian can read and understand?

Yes  No

If not, what did you do? \_\_\_\_\_

3) Was the material reviewed with the parent or guardian? Yes  No

If yes, list the materials provided: \_\_\_\_\_

If not, why? \_\_\_\_\_

4) Did the parent or guardian have an understanding of the educational materials after your review?

Yes  No

If not, what did you do? \_\_\_\_\_

### Social Service & Other Agency Referrals

1) Has the child(ren) been referred by the Primary Care Provider (PCP) to a regional lead treatment center?

Yes  No

If not, why? \_\_\_\_\_

2) Do you have information that would be helpful to the PCP providing medical follow-up for this child?

Yes  No  Date contacted: \_\_\_\_\_

Information provided: \_\_\_\_\_

3) Are the conditions in the home indicative of a referral to the Dept. of Children & Families (DCF) Yes  No

**If yes – to make a child abuse or neglect report, call 1-800-842-2288 (DCF Careline)**

[DCF-136 Form - Report of Suspected Child Abuse or Neglect](#)

4) **WIC Referral** – Nutritious food and nutritional educational assistance to eligible pregnant women, postpartum women up to six (6) months, breastfeeding women up to one (1) year after deliver, and infants and children up to the fifth (5<sup>th</sup>) year. Is a referral required? Yes  No

**If yes, provide local contact number or Infoline number 2-1-1.**

5) **Early Head Start/Head Start** – Early Head Start/Head Start is a child development program for low-income families. Each Early Head Start/Head Start program is responsible for determining its' own eligibility criteria. Family income is one key factor in determining eligibility. Early Head Start programs are for children aged 0-3 years old. Head Start programs are for children 3-5 years old. Is a referral required? Yes  No

**If yes, provide local contact number or Infoline number 2-1-1.**

6) **Non-Insured/Under Insured HUSKY** – Connecticut children's health insurance plan provides managed care health insurance, including medical, dental, vision, and behavioral health care for children ages 0 through 18. The HUSKY program is administered by the Conn. Department of Social Services. Is referral required? Yes  No

**If yes, provide local contact number or Infoline number 2-1-1.**

7) **Birth to Three** – The Birth to Three Systems is a program for children up to age three years who have delays or disabilities. If the child's lead level is 10 µg/dL or greater they are automatically eligible for services. If lower than 10 µg/dL but the family has concerns about their child's learning, a free developmental evaluation will determine eligibility.

Does the parent or guardian want a free developmental evaluation for their child(ren)? Yes  No

**If yes, ask the parent to call the Child Development Infoline (CDI) at 1-800-505-7000 while you wait.**

8) If abatement funding sources are available for the town the property is located, has information been or will it be provided to the property owner? Yes  No  N/A

**If yes, list date provided and source(s) of possible funding.** \_\_\_\_\_

**Interim Control Measures Taken to Prevent Further Lead Exposure to the Family and Child(ren)**

Address of Property:

Date(s) of Inspection:

<p>Immediate relocation of <sup>1</sup>:</p> <p>Child <input type="checkbox"/></p> <p>Entire Family <input type="checkbox"/></p> <p>No Immediate Relocation <input type="checkbox"/></p>	<p>Relocation Date: _____</p> <p>Relocation Address: _____</p> <p>List measures to ensure that relocation address is lead-safe (i.e. XRF testing, dust wipe sampling, visual inspections, etc.):</p>
<p>Interim control measures implemented in primary residence.</p> <p>Flush drinking water faucet prior to use <input type="checkbox"/></p> <p>Prevent tracking of soil into home <input type="checkbox"/></p> <p>Prohibit or limit at risk occupation/hobbies <input type="checkbox"/></p> <p>Limit access to porches, soil, windows, etc. <input type="checkbox"/></p> <p>Use of HEPA vacuum <input type="checkbox"/></p> <p>Wet cleaning of floors and windows <input type="checkbox"/></p> <p>Other <input type="checkbox"/></p>	<p>Further explain who implemented measures and specific locations related to each checked box(es):</p>
<p>Temporary relocation during abatement ONLY <sup>1</sup> <input type="checkbox"/></p>	<p>Relocation Date: _____</p> <p>Relocation Address: _____</p> <p>List measures to ensure that relocation address is lead-safe (i.e. XRF testing, dust wipe sampling, visual inspections, etc.):</p>
<p>No relocation during abatement <sup>1</sup> <input type="checkbox"/></p>	<p>List measures to ensure that abatement can be performed safely while occupancy continues and that access to required amenities will be maintained throughout the term of the abatement project:</p>

<sup>1</sup> Per CGS §19a-111: "The local director of health may permit occupancy in said residential unit during abatement if, in his or her judgement, occupancy **would not** threaten the health and well-being of the occupants".

Use this space to document contact attempts (i.e. telephone calls, visits to home, letters sent) and method (1<sup>st</sup> class or certified mail), etc. and any other information regarding this investigation (e.g., discussions with health provides, social service agencies or other individuals).