

**Oregon Department of Human Services  
Childhood Lead Poisoning Prevention Program  
Medical Information Form**

Provider name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Child's date of birth \_\_\_\_\_

When was the last time you examined this child? \_\_\_\_\_

Is the child a recent adoptee or immigrant from outside the U.S.? \_\_\_\_\_

Why was the blood lead test performed?	Other tests	Date performed	Results
<input type="checkbox"/> (1) EPSDT (early periodic screening, diagnostic & treatment)	Hemoglobin		
<input type="checkbox"/> (2) Routine Screen	Hematocrit		
<input type="checkbox"/> (3) Known exposure to lead	Serum Iron		
<input type="checkbox"/> (4) Parental request	Iron Binding		
<input type="checkbox"/> (5) Special screening project	Ferritin		
<input type="checkbox"/> (6) Anemia/Iron deficiency	Abdominal X-ray		
<input type="checkbox"/> (7) Symptoms of lead poisoning			
<input type="checkbox"/> (8) Don't know			
<input type="checkbox"/> (9) Other _____			

Check all possible symptoms and risk indicators listed below that may apply:

Neurological	Developmental	Gastrointestinal	Other
<input type="checkbox"/> Seizures	<input type="checkbox"/> Developmental delays	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> None
<input type="checkbox"/> Encephalopathy	<input type="checkbox"/> Growth delays	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Lethargy
<input type="checkbox"/> Headache	<input type="checkbox"/> Language delays	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Sleeplessness
<input type="checkbox"/> Autism	<input type="checkbox"/> Pica	<input type="checkbox"/> Nausea	<input type="checkbox"/> Irritability
<input type="checkbox"/> Hyperactivity/attention deficit disorder	<input type="checkbox"/> Atypical hand to mouth behavior	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Behavioral change
<input type="checkbox"/> Hearing deficits		<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Muscle weakness
		<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle soreness
			<input type="checkbox"/> Anemia

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Pertinent medical history & remarks:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If child has growth delay has child received a nutritional evaluation?	Yes	No
Result:		
Is child taking supplements (Ca, Fe, Zinc)?		
Has child been referred to WIC?		
Has child received or been referred for formal neuro-developmental assessment?	Yes	No
Result:		

**Note: Include history of elevated blood lead level (EBLL) in problem list of child's permanent medical record.**

Was child hospitalized for lead poisoning?  Yes  No  Don't know

<b>If yes, where hospitalized?</b>	
Name of Hospital:	
Address and phone:	
Date admitted:	Date discharged:

Blood Lead Level (BLL)	Collection Date:	BLL Result:
On admission:		µg/dl
Other BLL:		µg/dl
Other BLL:		µg/dl
Other BLL:		µg/dl
On discharge:		µg/dl

Was child chelated?  Yes  No  Don't know If yes, date started? \_\_\_\_\_

If yes, with what (Check all that apply):  EDTA  BAL  DMSA/Succimer (Chemet)  Penicillamine

Don't know  Other \_\_\_\_\_

Was child chelated on an outpatient basis?  Yes  No  Don't know

If yes, date started? \_\_\_\_\_ Date ended: \_\_\_\_\_

If yes, with what (Check all that apply):  DMSA/Succimer (Chemet) \_\_\_\_\_

Don't know  Other \_\_\_\_\_

Pertinent medical history & remarks:

---

---

---

---

---

---

---

---

