Ohio Department of Health

Public Health Lead Investigation and Case Management Questionnaire

This questionnaire should be completed as part of a Public Health Lead Investigation and/or during a Lead Case Management visit. **Section IV** is not a required component of the Public Health Lead Investigation process, but shall be completed during a case management visit by a lead case manager. If a case manager completes this entire form as part of a Public Health Lead Investigation then it must be reviewed and signed by a Public Health Lead Investigator approved by the Ohio Department of Health (ODH) under current agreement as a Delegated Authority to perform Public Health Lead Investigations. A completed questionnaire without the signature of a licensed lead risk assessor cannot be used as documentation for a Public Health Lead Investigation. For further information on this form call **1-877-LEAD-SAFE (1-877-532-3723).**

Date ___________________

I. DEMOGRAPHICS

Name ____________________ DOB ____________ ☐ Male ☐ Female

Birth Country ____________ Ethnicity ____________ Race ____________ Medicaid # ____________

Lived outside US in last year? ☐ **Yes** ☐ **No** Country ____________ Date moved to U.S. ____________

Other children less than 6 years old in household

Name	Relationship	DOB

Current address ____________________

Date child moved in? ____________ Year built? ____________ ☐ Own ☐ Rent

If rented, are there any rent subsidies? ☐ Public housing authority ☐ Section 8 ☐ Other ____________

Previous addresses (past year)	Date child moved in	Date child moved out

Guardian Name	Relationship	Occupation	Interviewed?
			☐ Yes ☐ No
			☐ Yes ☐ No

Home Phone____________ Mobile Phone ____________ May we text you? ☐ Yes ☐ No

Email ____________________

II. POTENTIAL EXPOSURE

A. Work/Hobby

WORK

Does anyone who spends time with your child work with lead (e.g. foundry, scrapping, construction, automotive, shooting range, or manufacturing)? ☐ **Yes** ☐ **No**

Who ____________________ Occupation: ____________________

Source of exposure? ____________________

How long has this individual done this type of work? ____________________

Is clothing changed before leaving work? ☐ Yes ☐ No

Is shower taken before leaving work? ☐ Yes ☐ No

Are routine blood lead tests performed? ☐ Yes ☐ No

HOBBY

Does anyone who spends time with your child have a hobby that involves lead (e.g. hunting, fishing, scrapping, home remodeling, shooting range, or arts & crafts)? ☐ **Yes** ☐ **No**

Who? ____________________

How often are these activities done? ____________________ Are the hobbies done inside the building? ☐ Yes ☐ No

What does the hobby involve? ____________________

If hobby is done outside the home, is the clothing changed before entering the building? ☐ Yes ☐ No

Is shower taken before entering the home? ☐ Yes ☐ No

B. Home Remedies/Food/Drink

Does your child use herbal/ayurvedic remedies or vitamins (e.g. turmeric, azarcon, and greta)? ☐ **Yes** ☐ **No**

What remedy? ____________________

Date last given? ____________________ How many times in the last year? ____________________

How much? ____________________ How often? ____________________

For what purpose was the remedy given? ____________________

Do you have any imported or handmade ceramics in the building? ☐ **Yes** ☐ **No**

Describe their use ____________________

Are any of the following cosmetics ever used on your child: Kohl, Kajal, Surma or Sindoor? ☐ **Yes** ☐ **No**

How long (days) was it used? ____________________ Date last use ____________________

How many times was it used in the last year? ____________________

Does your child eat/drink food made in other countries? ☐ **Yes** ☐ **No** Food/drink item ____________________

Was the food item bought in the US? ☐ Yes ☐ No Where? ____________________

How much was given to your child? ____________________ Date last given? ____________________

How often given? ____________________ For how long? ____________________

II. POTENTIAL EXPOSURE

C. Behavior

Has your child been seen eating or mouthing other items (e.g. toys, newspapers, or magazines)? ☐ **Yes** ☐ **No**

Specify ______________________________

Does your child suck his/her thumb and/or fingers? ☐ **Yes** ☐ **No**

D. Frequented Properties

Is your child cared for away from home ≥6 hours a week? ☐ **Yes** ☐ **No**

Name of caregiver ______________________________ Phone ______________

Address ______________________________

How many hours/week? ______________ Start date ______________ End date ______________

Building condition ______________________________ Construction date ______________

Name of caregiver ______________________________ Phone ______________

Address ______________________________

How many hours/week? ______________ Start date ______________ End date ______________

Building condition ______________________________ Construction date ______________

Does your child attend child care, pre-school, or grade school? ☐ **Yes** ☐ **No**

Name of child care ______________________________ Phone ______________

Address ______________________________

How many hours/week? ______________ Start date ______________ End date ______________

Building condition ______________________________ Construction date ______________

Name of school ______________________________ Phone ______________

Address ______________________________

How many hours/week? ______________ Start date ______________ End date ______________

Building condition ______________________________ Construction date ______________

III. ENVIRONMENTAL QUESTIONS

PAINT QUESTIONS	Current Residence	Previous Address	Child Care Facility	School	Address: ________
Any recent repainting/remodeling?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Any paint chips in window troughs or on window sills?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Chipping or flaking paint inside or outside?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Chipping or flaking paint on an outbuilding or other structure?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Has your child chewed on painted surfaces, eaten paint chips, or picked at deteriorated paint?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
SOIL QUESTIONS					
Is there any bare dirt outside?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Has your child eaten any dirt or gotten it in his/her mouth?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Are there any paint chips on the ground outside?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
WATER QUESTIONS					
Does the property obtain water from a well?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Does your child drink tap water or eat foods cooked in it?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
Do you use the water immediately?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					
ON-SITE NEEDED? (LEAD INVESTIGATOR ONLY FOR EBLL ≥10 µG/DL)					
On-site investigation necessary?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Comment: ________					

____

Public Health Lead Investigator (print) **(Signature)** **Date**

PROPERTY OF CONCERN: ____

Property Owner Name ____ Phone Number ____________

(Note: if more than one on-site investigation is conducted then use additional questionnaires for documentation.)

IV. EXPOSURE

A. Residential

Please list below any deteriorated paint from the home visit including all areas of the home (e.g. interior/exterior of home, porches, decks, out buildings, and garages) as well as proximity to off-site lead sources (e.g. industry, major roadways, and construction sites).

____

____

____

____

____

____

____

____

B. Other Sources

List other potential sources discussed (e.g. antique furniture, toys, and pets).
Description (including brand name if applicable):

____

____

____

____

____

Duration of use/exposure:____

Have these potential sources been tested? ☐ Yes ☐ No

By whom? ____

ATTENTION: SECTION IV ONLY

Needs to be completed by a Local Lead Poisoning Case Manager.

V. MEDICAL/DEVELOPMENTAL INFORMATION

A. Nutrition Information

Does your family receive food stamps (SNAP)? ☐ **Yes** ☐ **No**

Was a nutrition assessment done on your child or is your child enrolled in the WIC program? ☐ **Yes** ☐ **No**

By whom?____

Is or was your child breastfed? ☐ **Yes** ☐ **No** During what ages? ____________________________

Has your child ever been anemic (low iron)? ☐ **Yes** ☐ **No** When? ____________________________

Has your child been given iron supplements? ☐ **Yes** ☐ **No**

Are you concerned about your child's nutrition or is your child a picky eater? ☐ **Yes** ☐ **No**

Do you feel that your family needs help getting food? ☐ **Yes** ☐ **No**

B. Developmental Information

Has child had developmental testing or is your child enrolled in the *Help Me Grow Program?* ☐ **Yes** ☐ **No**

What type of testing?____

Have any developmental delays been identified in your child? ☐ **Yes** ☐ **No**

Does your child receive any special services currently (speech, physical or occupational therapy)? ☐ **Yes** ☐ **No**

What kind of therapy? ____

Is your child's development progressing as you have expected? ☐ **Yes** ☐ **No**

If no, explain____

Notes for Case Manager to document other delays:

____

____

____

____

____

____

____

V. MEDICAL/DEVELOPMENTAL INFORMATION

C. Medical Information

Who is your child's primary care physician (PCP)? ________________ Has the PCP been notified? ☐ Yes ☐ No

Does your family have health insurance? ☐ **Yes** ☐ **No** Specify ________________

Is your child currently on medication? ☐ **Yes** ☐ **No** Specify ________________

Does your child have any other medical problems (e.g. asthma or diabetes)? ☐ **Yes** ☐ **No**

Specify ________________ ________________

Has your child had any symptoms of lead poisoning (headache, stomachache, irritability, etc.)? ☐ **Yes** ☐ **No**

Specify ________________

D. Chelation

Has your child received chelation therapy? ☐ **Yes** ☐ **No** What chelating agent ________________

Start date ________________ End date ________________

Was your child hospitalized for chelation? ☐ **Yes** ☐ **No**

Institution? ________________ Physician? ________________

E. Referrals

Do you consent to have your child screened for developmental delays at no cost to you? ☐ **Yes** ☐ **No**

Do you consent to having your case referred to other programs? (Check each below for all "Yes" answers)

☐ Healthy Start/Families (Medicaid) ☐ Help Me Grow ☐ School system ☐ Remediation Services

☐ HEPA Vacuum Loan Program ☐ WIC ☐ Primary Care Provider ☐ Head Start

☐ BCMH ☐ Iron Testing

____

Case Manager (print) (Signature) Date