Oregon Health Authority
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
□ (1) EPSDT (early periodic screening, diagnostic & treatment) □ (2) Routine Screen □ (3) Known exposure to lead □ (4) Parental request □ (5) Special screening project □ (6) Anemia/Iron deficiency □ (7) Symptoms of lead poisoning □ (8) Don't know □ (9) Other _____	Hemoglobin		
	Hematocrit		
	Serum Iron		
	Iron Binding		
	Ferritin		
	Abdominal X-ray		

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

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

If child hospitalized or chelated see back of form.

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

If yes, where hospitalized?	
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:

_____

_____

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