Reset Form

HOME VISIT

State Form 56458 (R2 / 1-25)
INDIANA DEPARTMENT OF HEALTH

INDIANA DEPARTMENT OF HEALTH
LEAD AND HEALTHY HOMES DIVISION
2 N. Meridian St., 7th Floor
Indianapolis, IN 46204
Fax number: (317) 233-1630

INSTRUCTIONS: 1. Please type or print.
2. Return this completed form to the above address within ten (10) business days.

Interviewer	Date of home visit *(month, day, year)*
Agency	
Person interviewed	Relationship

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

Last name	First name
Address *(number and street, city, state, and ZIP code)*	
Length at residence _____ Years _____ Months / Meses	Medicaid number
Elevated blood lead (EBL) level ☐ Venous / Capillary	Blood lead level (BLL) test date *(month, day, year)*
Is this an Initial Home Visit? ☐ Yes ☐ No	Is mother pregnant? ☐ Yes ☐ No

Date of birth *(month, day, year)*	Age	Sex ☐ Male ☐ Female

Race / Raza
☐ African American ☐ Native American ☐ Asian/Pacific Islander
☐ Caucasian ☐ Multiracial ☐ Other ☐ Unknown

Ethnic origin
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Name of parent / guardian	Relationship to child

Home telephone	Work telephone	Cellular telephone
( )	( )	( )

Who to contact if you move?	Name	Telephone number
		( )

List where child has lived in the past twelve (12) months.

Address *(number and street, city, state, and ZIP code)*	**City / State**	**County**	**Years / Months**

Other household members: ***Note children less than seven (7) years of age, pregnant women, and adults employed in jobs that may expose them to lead.***

Name	Relationship to child	Date of birth *(month, day, year)*	Age	Occupation

List where child spends more than six (6) hours a week, other than home.

Name of Location	Address *(number and street, city, state, and ZIP code)*	Telephone Number	Time Spent at Location

MEDICAL INFORMATION

Has child ever been hospitalized?

☐ Yes ☐ No

If yes, when and why?

Does child have any other medical conditions or health issues?

Does child have any behavioral issues/problems?

Name of Physician/Provider/Clinic	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	County

Do any adults in the household work in a lead industry? ***(Lead smelters and foundries, radiator repair shops, battery manufacturers, construction, glass and ceramic industries, etc.)***

Who?	What Occupation?	How long employed there?	Is clothing changed before leaving work?	Is shower taken before leaving work?	Is routine blood lead test given?

Does anyone in the home have a hobby involving lead? *(Soldering, stained glass, bullet making, ceramics, working on cars, etc.)*
Does anyone in the home use any off brand or imported cosmetics? (*Nail polish, lipstick, skin cream, eyeliner, etc.)*
Does family use home remedies?

Name of homeowner	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	
When was the house built?	
What type of dwelling? ☐ Single Family ☐ School ☐ Unknown ☐ Multi-Unit ☐ Daycare ☐ Other	
What type of occupancy? ☐ Owner Occupied ☐ Public Housing ☐ Unknown ☐ Private ☐ Rental ☐ Section ☐ Other	

Does child crawl? ☐ Yes ☐ No
Does child eat or chew on non-food items: *paint chips, ashes, cigarette butts, batteries, paper, pencils/crayons*? ☐ Yes ☐ No
Does child eat dirt? ☐ Yes ☐ No
Does child suck on batteries or other materials containing lead compounds: *lacquers, pipe sealants, putty, gasoline, oil, epoxy resin, dyes, etc.*? ☐ Yes ☐ No
Is there peeling paint inside or out or evidence of lead fallout on windowsills, railings, porches, and outside steps or peeling paint on neighbors homes, garages or fences? ☐ Yes ☐ No
Has residence been remodeled in the last six (6) months? ☐ Yes ☐ No
Does child have exposure to homemade or imported ceramic dishes? ☐ Yes ☐ No
Does family store food in open cans and/or ceramic containers, especially acid foods such as fruit juices, vinegars, homemade wines, etc.? ☐ Yes ☐ No
Is dwelling located within two (2) blocks of a freeway or major thoroughfare? ☐ Yes ☐ No
Is dwelling located near a lead related industry? ☐ Yes ☐ No
Is there peeling paint where child likes to play? ☐ Yes ☐ No
Where, on the inside and outside of home, does child like to play?
Where do you think child is getting lead exposures?
Does your child have any health/medical/dental problems diagnosed by a doctor? ☐ Yes ☐ No

Does your child use utensils?

☐ Yes ☐ No

Can your child feed him/herself?

☐ Yes ☐ No

Does your child have any food/drink allergies?

☐ Yes ☐ No

Are you concerned about your child's eating habits?

☐ Yes ☐ No

What are particular food/drink items you child does NOT prefer to eat? *Please list.*

Does your child take any of the following?

☐ Medications – *If so please list.* _____

☐ Vitamins ☐ Herbs ☐ Homemade Remedies ☐ Supplements

☐ Other _____

Do you have a working?

☐ Stove Top ☐ Oven ☐ Microwave ☐ Refrigerator

Where does your child typically eat?

☐ In a highchair ☐ At the table ☐ On the sofa ☐ In a restaurant

☐ In school ☐ In the car ☐ At childcare ☐ Head Start/preschool

☐ With the TV ☐ With family and friends ☐ Alone

☐ Other _____

At meal times, how often does your child eat the same foods as the rest of the family?

☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

What types of food does your child eat?

☐ Breast/Bottle Only ☐ Baby Food ☐ Table Food

☐ Coarsely chopped/sliced ☐ Mashed/Blended ☐ Finely Chopped

☐ Other _____

How many times does your child eat each day?

Snacks _____ Meals _____

What snack foods does your child usually eat?

☐ Fruit ☐ Fruit Snacks ☐ Cookies/Snack Cakes ☐ Crackers

☐ Chips/Popcorn ☐ Nuts ☐ Pretzels ☐ Ice Cream

☐ Cereal ☐ Vegetables ☐ Cheese ☐ Yogurt ☐ Hard Candies

☐ Soda/Pop ☐ Raisins ☐ Other: _____

How many times does your child eat fruits and vegetables each day?

What types of fruits and/or vegetables will your child eat?

☐ Apples/Applesauce ☐ Bananas ☐ Grapes ☐ Oranges ☐ Pears

☐ Potatoes ☐ Squash ☐ French Fries ☐ Corn ☐ Green Beans

☐ Carrots ☐ Sprouts ☐ Tomatoes ☐ Greens/Lettuce ☐ Onions

☐ Broccoli ☐ Melons ☐ Berries ☐ Other: _____

How many times does your child eat protein during a normal day?

Which protein rich foods will your child eat?

☐ Beef/Hamburgers ☐ Venison ☐ Chicken ☐ Turkey

☐ Fish/Seafood ☐ Pork/Ham/Bacon ☐ Hot Dogs/Lunch Meat

☐ Yogurt ☐ Eggs ☐ Peanut Butter ☐ Tofu ☐ Beans

☐ Cheese (Not pre-sliced or Velveeta) ☐ Cottage Cheese

☐ Other: _____

What does your child drink from?

☐ Breast ☐ Bottle ☐ Sippy Cup ☐ Glass/Cup

What type of milk does your child usually drink?

☐ Whole (Vitamin D) ☐ Reduced/Low Fat (2%, 1 % or ½ %)

☐ Skim ☐ Lactose Free ☐ Goat Milk ☐ Evaporated Milk

☐ Sweetened Condensed ☐ Soy Milk ☐ Rice Milk

☐ Other: _____

How many cups of MILK does your child drink during a normal day?

How much MILK does your child drink each time? *(In ounces)*

Do you ever add flavoring to the child's milk?

☐ Yes ☐ No

What?

How many cups of WATER does your child drink during a normal day?

How much WATER does your child drink each time? *(In ounces)*

What kind of water does your child usually drink?

☐ City ☐ Rural ☐ Well ☐ Bottled ☐ Filtered
☐ Unsure ☐ Other: _____

How many cups of JUICE does your child drink during a normal day?

How much JUICE does your child drink each time? *(In ounces)*

Do you dilute the juice with water?

☐ Yes ☐ No

FOR ADMINISTRATIVE USE ONLY.

REFERRALS			
	YES or NO	**AGENCY**	**DATE *(month, day, year)***
Was a referral made for developmental assessment?			
Was a referral made for nutritional assessment?			
Was a referral made to WIC?			
Was a referral made to Head Start?			

NOTES

Please check the specific event code(s) that occurred in this case and record the date.			
Result Codes: C - Complete; **L** - Could Not Locate; **M** - Moved; **N** - No One Home; **O** - Incomplete, Other; **R** - Refused			
Event Code	**Event Description**	**Date Completed *(month, day, year)***	**Result Code**
☐ 0CNTP	Contact Attempt by Telephone		
☐ 0CNTL	Contact Attempt by Letter		
☐ 0IHVN	Initial Home Visit by Public Health Nurse		
☐ 0IHVC	Initial Home Visit by Case Manager		
☐ 0HVED	Home Visit for Lead Education		
☐ 0HVOT	Home Visit for Any Other Reason		
☐ 0MIRO	Referred for Iron Deficiency		
☐ 0MCHI	Chelation, Inpatient		
☐ 0MCHO	Chelation, Outpatient		
☐ 0RFRA	Referred to Licensed Risk Assessor		
☐ 0HVRA	Risk Assessment Completed		
☐ 0HVDA	Developmental Assessment Conducted		
☐ 0DARF	Referral for Developmental Assessment		
☐ 0HDST	Headstart Participant		
☐ 0HSRF	Referral for Headstart Services		
☐ 0WICP	WIC Participant		
☐ 0WICR	WIC Referral		
☐ 0HVNA	Nutritional Assessment Conducted		
☐ 0NARF	Referral for Nutritional Assessment		

Completed by: *(Please print.)*	Date *(month, day, year)*