

LEAD RISK ASSESSMENT QUESTIONNAIRE

Patient's Name: _____

Medical Record Number: _____

Purpose: For clinical use to identify children who need to be screened for lead poisoning. All children should receive a blood lead test at both **12** and **24** months of age (or between 24 and 72 months of age if they have never been tested) unless the child lives in one of the low-risk zip codes listed on the back of this page and the answers to all five screening questions are no.

Instructions: At 12 and again at 24 months of age (or at the time of the clinic visit closest to these ages) determine the residential zip code for all children. Also determine the zip code for children between 24 and 72 months of age who have never been tested or for whom lead screening status is unknown. Conduct a blood lead test for children who do not live in one of the low risk zip codes listed on the back of this page. For children who live in low risk zip codes ask the five screening questions. A **yes** or **I don't know** answer to any question also indicates the need for a blood lead test.

Reordering Information: Additional copies of this form may be ordered from:
Environmental Health Services Section
Division of Environmental Health
P. O. Box 29534
Raleigh, NC 27626-0534

Date: _____ **Age:** _____ **Residential Zip Code:** _____

- | Does your child: | Yes | No | I don't know |
|--|------------|-----------|---------------------|
| 1. Receive Women, Infants, and Children (WIC) Program Services or is your child enrolled in Medicaid (Health Check) or Health Choice? | | | |
| 2. Live in or regularly visit a house that was built before 1950, including home child care centers or homes of relatives? | | | |
| 3. Live in or regularly visit a house that was built before 1978, with recent or ongoing renovations or remodeling (within the last 6 months)? | | | |
| 4. Live in or regularly visit a house that contains vinyl miniblinds? | | | |
| 5. Have a brother, sister, other relative, housemate or playmate who has or has had a high blood lead level? | | | |

Date: _____ **Age:** _____ **Residential Zip Code:** _____

- | Does your child: | Yes | No | I don't know |
|--|------------|-----------|---------------------|
| 1. Receive Women, Infants, and Children (WIC) Program Services or is your child enrolled in Medicaid (Health Check) or Health Choice? | | | |
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| 4. Live in or regularly visit a house that contains vinyl miniblinds? | | | |
| 5. Have a brother, sister, other relative, housemate or playmate who has or has had a high blood lead level? | | | |