DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44771A (04/2023)

STATE OF WISCONSIN
Wis. Stat. § 254.15
Phone 608-266-5817, Fax 608-267-0402

NURSING CASE MANAGEMENT REPORT

Case Management of Children with Lead Poisoning

Reset Form

Completion of this form is mandatory for agencies contracting with the Division of Public Health for program funding. Personal identifiable information collected on this form will be used to document a completed home visit, assess the developmental status and determine the services needed. Data will be used in the aggregate to assist research and project future service needs. Nursing case management should follow the Case Management Protocol in the Wisconsin Childhood Lead Poisoning Prevention Program Handbook.

CHILD INFORMATION

Name of Child (last, first, middle initial)

Date of Birth (MM/DD/YYYY)	Sex	Ethnicity
	☐ Male ☐ Female	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown

Race (check all that apply)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

☐ Unknown ☐ Other (specify): _____

Current Street Address	Apt. No.	City	County	Zip Code

Name of Legal Guardian (last, first)

DEVELOPMENTAL ASSESSMENT

Name of Case Manager (last, first)

Home Visit
Date completed (MM/DD/YYYY): _____

or

Home Visit Incomplete (indicate reason):
☐ Family refused ☐ Other (describe): _____

Developmental Screening Test
Date completed (MM/DD/YYYY): _____
Completed by: ☐ Case manager ☐ Provider or other

or

Screening Test Incomplete (indicate reason):
☐ Family refused ☐ Other (describe): _____

Developmental Screening Results (check all that apply):
☐ Within normal limits
or
Delays noted in: ☐ Language ☐ Personal-social ☐ Gross motor skills ☐ Fine motor skills ☐ Problem solving ☐ Other (describe): _____

If two or more delays are identified, standard of practice followed was (check all that apply):
☐ Scheduled repeat test according to developmental screening best practices
☐ Referred to health care provider
☐ Referred for developmental services (see below)

The child or family has been **referred** to the following programs or services (check all that apply):
☐ None (refused referral)
☐ No referral needed
☐ Birth to 3
☐ Head Start or Early Head Start
☐ Occupational therapy
☐ Speech therapy
☐ Women, Infants, and Children Program (WIC)
☐ Other childhood or early childhood service(s) (describe): _____

The child or family is **currently enrolled** in the following programs or services (check all that apply):
☐ None (refused referral)
☐ No referral needed
☐ Birth to 3
☐ Head Start or Early Head Start
☐ Occupational therapy
☐ Speech therapy
☐ Women, Infants, and Children Program (WIC)
☐ Other childhood or early childhood service(s) (describe): _____

Comments:

Attach this completed form to the case record in HHLPSS (see Job Aid 3.14, Patient Attachments, at https://www.dhs.wi.gov/publications/p02299-3-14.pdf). Contact the Wisconsin Childhood Lead Poisoning Prevention Program at 608-266-5817 or DHSLeadPoisoningPrevention@wi.gov when all documents have been uploaded to the case record.