DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44771A (Rev 11/06)

STATE OF WISCONSIN
ss. 254.15, Wis. Stats
Phone (608) 266-5817
FAX (608) 267-0402

NURSING CASE MANAGEMENT REPORT

Case Management Of Children with Elevated Blood Lead Levels*

*Elevated Blood Lead Level (EBLL) = 1 venous Blood Lead Level (BLL) ≥20 mcg/dL **OR**
2 venous BLLs of ≥15 mcg/dL drawn at least 90 days apart.

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	MI	Date of Birth (mm/dd/yy)

Current Street Address	Apt. No.	City	County	Zip Code

Race ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Multi-racial ☐ White ☐ Other (specify):

Ethnicity ☐ Hispanic ☐ Non-Hispanic | Gender ☐ Male ☐ Female

Legal Guardian Name Last First

DEVELOPMENTAL ASSESSMENT

Name of Case Manager — Telephone No. (include area code)

Date of Home Visit: (mm/dd/yy)
(must be completed before form is submitted)

Date of Developmental Screening Test: (mm/dd/yy)

Results of Developmental Screening Test were:
☐ Within Normal Limits

Delays noted in: ☐ Language ☐ Gross Motor Skills ☐ Fine Motor Skills ☐ Personal-Social ☐ Other (specify):

If 2 or more delays are identified, standard of practice followed was:
☐ Repeat test scheduled in 2-4 weeks
or
☐ Referral for developmental services. Give name of provider:

The child or family is enrolled in the following programs:
☐ Head Start ☐ Birth to 3/Early Intervention ☐ Early Childhood ☐ Parenting
☐ 4-Year Kindergarten ☐ Children with Special Health Care Needs (Regional CSHCN Center)
☐ Other (describe):

The child or family has been referred to the following programs:
☐ Head Start ☐ Birth to 3/Early Intervention ☐ Early Childhood ☐ Parenting
☐ 4-Year Kindergarten ☐ Children with Special Health Care Needs (Regional CSHCN Center)
☐ Refuses referral
☐ Other (describe):

Comments:

Send completed form to: **DEPARTMENT OF HEALTH SERVICES**
Division of Public Health
Childhood Lead Poisoning Prevention Program
P. O. Box 2659, Room 145
Madison, WI 53701-2659