

Patient Name: _____ Date of Birth: ____/____/____

Please tell me any concerns, questions, problems you have about the way your child is behaving, developing/growth and/or learning:

DEVELOPMENTAL QUESTIONS AND OBSERVATIONS

- YES NO Listens well and follows simple instructions
- YES NO Can tell a story with full sentences
- YES NO Counts to 10
- YES NO Names at least 4 colors
- YES NO Draws a person with 6 body parts
- YES NO Copies squares, triangles
- YES NO Writes some letters and numbers/good pencil control
- YES NO Balances on 1 foot
- YES NO Hops, skips, climbs
- YES NO Ties a knot
- YES NO Knows ABC's
- YES NO Cooperative at play
- YES NO Cuts and pastes
- YES NO Speech is all intelligible
- YES NO Dresses self/can fix cereal

Describe his/her diet by checking all that apply: Rich in Meat Egg Iron fortified Cereal Breads

TUBERCULOSIS

Was your child born in a country at high risk for tuberculosis (*countries other than the United States, Canada, Australia, New Zealand or Western Europe*)? YES NO

Has your child traveled (*had contact with resident populations*) for longer than one (1) week to a country at high risk for tuberculosis? YES NO

Has a family member or contact had tuberculosis or a positive tuberculin skins test? YES NO

Is your child infected with HIV? YES NO

DYSLIPIDEMIA

Does your child have parents or grandparents who have had a stroke or heart problem before age 55? YES NO

Does your child have a parent with elevated blood cholesterol (*240mg/dL or higher*) or who is taking cholesterol medication? YES NO

Additional comments:

Signature: _____ Date: _____ Relationship to Patient: _____

**OKLAHOMA CHILDHOOD LEAD POISONING PREVENTION PROGRAM
2012 LEAD EXPOSURE RISK ASSESSMENT QUESTIONNAIRE (LERAQ)**

Childs Name: _____ Date of Birth: ____/____/____

Date: ____/____/____ Age: ____ Current Residential Zip Code: _____

1. Does your child have Medicaid (SoonerCare)? If yes this child must have a blood lead test at 12 and 24 months of age (or, if older than 24 months, at least one test before 6th birthday).	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
2. Does your child live in a high risk ZIP code area? (see a list of high risk ZIPs on this form)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
3. Does your child live in or often visit a house or child care site with chipped or peeling paint that was built prior to 1950?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
4. Does your child live in or often visit a house or child care site built prior to 1950 with renovation, repairs or remodeling that were done in the last 6 months?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
5. Does your child live in or often visit a house or child care site that has vinyl or plastic mini blinds?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
6. Does your child have friends, siblings, house mates, or a play mate that has or did have lead poisoning?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
7. Does your child live with an adult who has a job or hobby where lead is used? Examples would be: oil field worker, bridge painter, demolition or renovation of buildings, automobile work with batteries or radiators, lead solder, metal plating, furniture refinishing, leaded glass, lead shot or bullets and lead fishing sinkers.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
8. Is your child given any home or folk remedies or cosmetics such as imported items called Greta, Azarcon, Rudea, Kohl or does your child eat food cooked in or served from pottery made outside the United States?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
9. Does your child chew on or mouth trinket jewelry or toys found in vending machines?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>

HIGH RISK ZIP CODES

73106 73108 73111 73119 73521 74104 74110 74127 74401 74447
 73107 73109 73117 73129 73701 74106 74115 74354 74403 74631
 74848

Lead Poisoning Prevention Program
Screening and Special Services
Oklahoma State Department of Health
1000 NE 10th Street

Telephone: (405) 271-6617 Toll Free:
1-800-766-2223

Purpose: The LERAQ is to be used to screen for possible lead exposure in children 6 -72 months of age.
Use: This assessment may be administered by medical staff or teacher, or completed by the child's parent or guardian.
Any "Yes" or "don't know" answer is considered a positive answer thus requires the child to have a blood lead test.

According to OCLPPP Case Management Guidelines, if a child has a blood lead test <5 ug/dl, reassess with the LERAQ in 1 year. No additional testing is necessary unless an exposure risk change has occurred. This Guideline does not supersede the federal CMS requirement that children enrolled in SoonerCare receive a blood lead test at 12 and 24 months of age as defined in the Child Health Check Up, also known as Early and Periodic Screening; Diagnosis and Treatment (EPSDT). Routing and Filing: Retain this record in the child's record to review annually.

ANEMIA RISK QUESTIONNAIRE

Patient Name: _____

Date of Birth: ____ / ____ / ____

1. Has your child ever been diagnosed with iron deficiency anemia?

Yes No

2. Do you ever have trouble getting food on the table?

Yes No

3. If your child is under the age of 6 months, was your child born premature?

Yes No

4. If your child is under the age of 6 months, did your child have a low birth weight?

Yes No

5. Is your child on a strict vegetarian diet?

Yes No

6. Does your child's diet include iron-rich foods like meat, eggs, beans or iron-fortified cereals?

Yes No

7. If your child is under the age of 6 months, is your child drinking anything besides breastmilk or iron-fortified formula?

Yes No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ Date: ____/____/____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Check boxes to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so figety or restless that you have been moving around a lot more than usual	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). **TOTAL:** _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult