REPORTING HEALTHCARE PROVIDER:
FAX THIS PAGE ALONG WITH LAB REPORT TO:
Hill County Health Department
F: 406-265-6976

Montana Department of Health and Human Services (DPHHS) Administrative Rule on Reportable Blood Lead [ARM 37.114.203]
a) Lead levels in a capillary blood specimen of ≥ 3.5 micrograms per deciliter(µg/dL) in a person less than 16 years of age
b) Lead levels in a venous blood specimen at any level for all ages

Lead Poisoning Case Report

TO BE COMPLETED BY THE REPORTING HEALTHCARE PROVIDER
Today's Date: __________ **Reporting Provider:** ________________________ **Ph:** ____________ **F:** ____________
Blood Lead Test Date: __________ **Result:** __________**µg/dL** ☐**Capillary** ☐**Venous(confirmatory)**
Is Follow-Up Testing Scheduled?: Yes No N/A **When is it Scheduled (date)?:** ________________________
Patient's Name (First, Last, MI): _________________________________ **DOB:** __________ **Sex:** F or M
Residential Address (physical): __________________________**City:** ____________ **State:** ____ **Zip Code:** _______
Race (circle all that apply): Asian African American Caucasian Native American Alaskan Native Native Hawaiian or other Pacific Islander **Ethnicity Latino/Hispanic?:** Yes or No
Patient's Contact Number: __________________ **If a Minor, Guardian/Parent Name:** _______________________

This questionnaire serves as a tool to show that appropriate control measures have been implemented per ARM 37.114.501. **The Montana Department of Public Health and Human Services requests this questionnaire be entered in MIDIS and/or faxed to the CD Epidemiology Section at 1-800-616-7460. Please direct questions to abbie.phillip@mt.gov or (406) 202-8866.**

TO BE COMPLETED BY - HILL COUNTY HEALTH DEPARTMENT -			
Today's Date: ____________			
Ordering Physician Contacted? Yes / No **If "Yes," re-testing has been scheduled?** Yes / No / Unknown **Date Scheduled:** ______			
If the patient is a child, do they attend a daycare?	Yes	No	Unknown
Is the patient enrolled in Medicaid?	Yes	No	Unknown
Is the patient a recipient of Women, Infants, and Children (WIC) Program Services?	Yes	No	Unknown
Has the patient been placed in your home through the foster care system?	Yes	No	Unknown
Does the patient live in or visit a home, daycare or other building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling?	Yes	No	Unknown
Do you live or have you lived in any assisted housing (Section 8, Public Housing, Project-Based Housing)?	Yes	No	Unknown
Does the patient live in a rental property?	Yes	No	Unknown
Does the patient eat or chew on non-food items such as paint chips or dirt?	Yes	No	Unknown
Is there a family member/friend who ever had an elevated blood level?	Yes	No	Unknown
Should other household members be tested for elevated blood lead?	Yes	No	Unknown
Additional people in the home that could be at risk ____			
Is the patient a refugee, immigrant, or adopted from another country?	Yes	No	Unknown
Country of Origin: ___________________________ Country of last residence (if different): ____________________________			

Is the patient exposed to contamination from a parent, relative or friend with jobs or hobbies such as any of these? Please check all that apply:

○ Pottery making	○ Batteries	○ Chemical preparation
○ Lead smelting	○ Lead-painted wood	○ Valve and pipe fittings
○ Welding	○ Automotive repair	○ Brass/copper foundry
○ Making fishing weights	○ Going to a firing range or reloading bullets	○ Refinishing furniture
○ House construction or repair		

Is the patient exposed to sources of lead in any of the following sources listed below? Please check all that apply:
- ○ Drinking water (pre-1986 household plumbing/fixtures, components of older private wells, >20 yrs.)
- ○ Imported or glazed pottery
- ○ Spices, candy, and food canned or packaged outside of the United States
- ○ Traditional remedies or nutritional supplements other than vitamins

Potential lead exposures not already indicated: ____

If the exposure was identified through occupational medical monitoring, indicate the following:
Industry (e.g. mining) ______________________________ Occupation (e.g. electrician) ______________________________
Employer___________________________________ Employer Contact Information ________________________________