

-- Insert local health jurisdiction logo here --

**REPORTING HEALTHCARE PROVIDER:**  
**FAX THIS PAGE ALONG WITH LAB REPORT TO:**  
 -- Insert local health jurisdiction contact info here

**Montana Department of Public Health and Human Services**  
**Administrative Rule on Reportable Blood Lead [ARM 37.114.203]**  
 a) Lead levels in a capillary blood specimen of  $\geq 3.5$  micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ) 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: _____ $\mu\text{g}/\text{dL}$		<input type="checkbox"/> Capillary		<input type="checkbox"/> 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   White   Native American   Alaskan Native   Native Hawaiian   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 [Amy.Hallmark@mt.gov](mailto:Amy.Hallmark@mt.gov) or (406) 444-0057.

### TO BE COMPLETED BY -- insert local health jurisdiction name here --

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	
Does the patient live (or have they previously lived) in assisted housing or received any financial assistance for housing? (ex. Housing Choice Voucher, Project-Based Section 8, Public 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 (list here)			
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 lead from a parent, relative or friend with jobs or hobbies involving? Please check all that apply:			
<input type="checkbox"/> Pottery making, stained glass	<input type="checkbox"/> Painting – artistic, residential, commercial	<input type="checkbox"/> Valve and pipe fittings	
<input type="checkbox"/> Smelting or mining	<input type="checkbox"/> Automotive repair or painting	<input type="checkbox"/> Brass/copper foundry	
<input type="checkbox"/> Welding or soldering	<input type="checkbox"/> Lead ammunition – hunting, shoot sports, reloading, retained bullets	<input type="checkbox"/> Refinishing furniture	
<input type="checkbox"/> Lead fishing weights or lures	<input type="checkbox"/> Hazardous materials/remediation	<input type="checkbox"/> Battery manufacturing/recycling	
<input type="checkbox"/> Construction – renovation or repair			
Is the patient exposed to sources of lead in any of the following sources listed below? Please check all that apply:			
<input type="checkbox"/> Drinking water (pre-1986 household plumbing/fixtures or private well)			
<input type="checkbox"/> Product recalls or alerts due to a lead hazard. See US Consumer Product Safety Commission ( <a href="http://www.cpsc.gov/Recalls">www.cpsc.gov/Recalls</a> ); US Food & Drug Administration ( <a href="https://www.fda.gov/food/recalls-outbreaks-emergencies/alerts-advisories-safety-information">https://www.fda.gov/food/recalls-outbreaks-emergencies/alerts-advisories-safety-information</a> )			
<input type="checkbox"/> Imported glazed pottery, leaded-glass, metal dishes, cookware, or food storage containers, antiques			
<input type="checkbox"/> Food and drink: spices, candy, food canned/packaged outside of the US, wild game harvested with leaded ammunition, home distilled spirits			
<input type="checkbox"/> 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 _____	