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| SEAL31.TIF | **HOME VISIT**  State Form 56458 (R / 4-23) | **INDIANA DEPARTMENT OF HEALTH**  **LEAD AND HEALTHY HOMES DIVISION**  2 N. Meridian St., 7th Floor  Indianapolis, IN 46204  Fax number: (317) 233-1630 |

*INSTRUCTIONS: 1. Please type or print.*

*2. Return this completed form to the above address within ten (10) business days.*

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| Interviewer / Entrevistador | | Date of home visit / Fecha de la visita domiciliaria  *(month, day, year)* / *(mes, día, año)* |
| Agency / Agencia | | |
| Person interviewed / Persona entrevistada | Relationship / Relación | |

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| **PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE** | | | | | | |
| Last name / Apellido | | | First name / Nombre | | | |
| Address *(number and street, city, state, and ZIP code)* / Dirección *(número y calle, ciudad, estado, y codigo postal)* | | | | | | |
| Length at residence / Tiempo viviendo en la residencia        Years / Años       Months / Meses | | | Medicaid number / Número del Medicaid | | | |
| Elevated blood lead (EBL) level / Nivel de EBL  Venous / Capillary        Venoso / Tubo capilar | | | Blood lead level (BLL) test date / Fecha de prueba de BLL  *(month, day, year)* / *(mes, día, año)* | | | |
| Is this an Initial Home Visit? / ¿Está es la visita domiciliaria inicial?  Yes / Sí  No / No | | | Is mother pregnant? / ¿Está la madre embarazada?  Yes / Sí  No / No | | | |
| Date of birth / Fecha de nacimiento *(month, day, year)* / *(mes, día, año)* | | Age / Edad | | Sex / Sexo  Male / Masculino  Female / Femenino | | |
| Race / Raza  African American / Americano Africano  Native American / Americano Nativo  Asian/Pacific Islander / Isleño Asiático/Pacífico  Caucasian / Blanco  Multiracial / Multirracial  Other / Otro  Unknown / Desconocido | | | | | | |
| Ethnic origin / Origen étnico  Hispanic / Hispano  Non-Hispanic / No Hispano  Unknown / Desconocido | | | | | | |
| Name of parent / guardian / Nombre del padre / guardian | | | Relationship to child / Relación con el niño | | | |
| Home telephone / Teléfono de la casa  (     ) | Work telephone / Teléfono del trabajo  (     ) | | | | Cellular telephone / Teléfono celular  (     ) | |
| Who to contact if you move? / ¿A quien contactar si se muda?) | | Name / Nombre | | | | Telephone number / Número del teléfono  (     ) |

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| ***List where child has lived in the past twelve (12) months. / Lista donde el niño ha vivido en los ultimo doce (12) meses.*** | | | |
| **Address *(number and street, city, state, and ZIP code)***  **Dirección *(número y calle, ciudad, estado, y codigo postal)*** | **City / State**  **Ciudad / Estado** | **County**  **Condado** | **Years / Months**  **Años / Meses** |
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| **Other household members: *Note children less than seven (7) years of age, pregnant women, and adults employed in jobs that may expose them to lead. /* Otros miembros del hogar: *mencione a los niños menores de siete años de edad, mujeres embarazadas y adultos que trabajen expuestos al plomo.*** | | | | |
| **Name**  **Nombre** | **Relationship to child**  **Relación con el niño** | **Date of birth *(month, day, year)***  **Fecha de nacimiento *(mes, día, año)*** | **Age**  **Edad** | **Occupation**  **Ocupación** |
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| ***List where child spends more than six (6) hours a week, other than home.***  ***Mencione los lugares donde el niño convive más de seis (6) horas a la semana, que no sea el hogar.*** | | | |
| **Name of Location**  **Nombre del Lugar** | **Address *(number and street, city, state, and ZIP code)***  **Dirección *(número y calle, ciudad, estado, y codigo postal)*** | **Telephone Number**  **Número de Teléfono** | **Time Spent at Location Tiempo que Convive**  **en el Lugar** |
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| **MEDICAL INFORMATION / INFORMACIÓN MÉDICA** | |
| Has child ever been hospitalized? / ¿El niño ha sido hospitalizado alguna vez?  Yes / Sí  No / No | |
| If yes, when and why? / Si sí, ¿cuando y por qué? | |
| Does child have any other medical conditions or health issues? / ¿EI niño tiene cualquier otra condición médica o problemas de salud? | |
| Does child have any behavioral issues/problems? / ¿EI niño tiene algún problema de comportamiento? | |
| Name of Physician/Provider/Clinic / Nombre del médico/proveedor de salud/de la clínica | Telephone number / Número del teléfono  (     ) |
| Address *(number and street, city, state, and ZIP code)* / Dirección *(número y calle, ciudad, estado, y codigo postal)* | County / Condado |

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| **Do any adults in the household work in a lead industry? *(Lead smelters and foundries, radiator repair shops, battery manufacturers, construction, glass and ceramic industries, etc.)***  **¿Alguno de los adultos en Ia casa trabajan en la iudustria del plomo? *(Fundidores de plomo, talleres de reparación de radiadores, fábricas de baterías, construcción, fábricas de vidrio y cerámica, etc.)*** | | | | | |
| **Who?**  **¿Quién?** | **What Occupation?**  **¿Cuál es la ocupación?** | **How long employed there?**  **¿Cuánto tiempo lleva empleado allí?** | **Is clothing changed before leaving work?**  **¿Se cambia de ropa antes de salir del trabajo?** | **Is shower taken before leaving work?**  **¿Se ducha antes de salir del trabajo?** | **Is routine blood lead test given?**  **¿Se hace la prueba de rutina de plomo en sangre?** |
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| Does anyone in the home have a hobby involving lead? *(Soldering, stained glass, bullet making, ceramics, working on cars, etc.)*  ¿Hay alguien en el hogar que tenga un pasatiempo que implique el uso de plomo? *(Soldadura, colorear vidrio, hacer balas, cerámica, trabajando en el coche/carro, etc.)* | | | | | |
| Does anyone in the home use any off brand or imported cosmetics? (*Nail polish, lipstick, skin cream, eyeliner, etc.)*  ¿Alguien en el hogar usa cosméticos importados o genéricos? (*Limpiador de uñas, lápiz labial, crema para la piel, delineador de ojos, etc...)* | | | | | |
| Does family use home remedies? / ¿La familia utiliza remedios caseros? | | | | | |

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| Name of homeowner / Nombre del dueño de casa | Telephone number / Número del teléfono  (     ) |
| Address *(number and street, city, state, and ZIP code)* / Dirección *(número y calle, ciudad, estado, y codigo postal)* | |
| When was the house built? / ¿Cuándo fue construida la casa? | |
| What type of dwelling? / ¿Qué tipo de vivienda es?  Single Family / Una Sola Familia  School / Escuela  Unknown / Desconocido  Multi-Unit / Unidad multiple  Daycare / Guardería  Other / Otro | |
| What type of occupancy? / ¿Qué tipo de uso le va a dar la vivienda?  Owner Occupied / Dueño  Public Housing / Vivienda pública  Unknown / Desconocido  Private / Privado  Rental / Alquiler privado  Section 8 / Sección 8  Other / Otro | |

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| Does child crawl? / ¿EI niño gatea?  Yes / Sí  No / No |
| Does child eat or chew on non-food items: *paint chips, ashes, cigarette butts, batteries, paper, pencils/crayons*?  ¿EI niño come o mastica artículos no alimenticios: *pintura, cenizas, colillas de cigarrillo, baterías, papel, Iápices/creyones*?  Yes / Sí  No / No |
| Does child eat dirt? / ¿EI niño come tierra?  Yes / Sí  No / No |
| Does child suck on batteries or other materials containing lead compounds: *lacquers, pipe sealants, putty, gasoline, oil, epoxy resin, dyes, etc.*?  ¿EI niño chupa baterías u otros materiales que esténcompuestos de plomo: *lacas, sellantes de tubos, masilla, gasolina, aceite, resina de epoxi, tintes, etc.*?  Yes / Sí  No / No |
| Is there peeling paint inside or out or evidence of lead fallout on window sills, railings, porches, and outside steps or peeling paint on neighbors homes, garages or fences? ¿Hay alguna peladura de pintura, al interior o exterior, o alguna evidencia de plomo en Ios travesaños de la ventana, pasamanos, pórticos, o en las gradas exteriores, o hay pintura pelada en las casas, garajes o rejas de los vecinos?  Yes / Sí  No / No |
| Has residence been remodeled in the last six (6) months? / ¿La residcncia se ha remodelado en los últimos seis (6) meses?  Yes / Sí  No / No |
| Does child have exposure to homemade or imported ceramic dishes? / ¿EI niño está expuesto a platos de cerámica hechos en casa o importados?  Yes / Sí  No / No |
| Does family store food in open cans and/or ceramic containers, especially acid foods such as fruit juices, vinegars, homemade wines, etc.?  ¿La familia almacena comida en latas abiertas y/o contenedores de cerámica, especialmente alimentos ácidos como jugos de fruta, vinagre, vinos caseros, etc.?  Yes / Sí  No / No |
| Is dwelling located within two (2) blocks of a freeway or major thoroughfare? / ¿La vivienda está ubicada a dos cuadras de una autopista o de una carretera importante?  Yes / Sí  No / No |
| Is dwelling located near a lead related industry? / ¿La vivienda está ubicada cerca de una fábrica que trabaje con plomo?  Yes / Sí  No / No |
| Is there peeling paint where child likes to play? / ¿Hay pintura pelada donde al niño le gusta jugar?  Yes / Sí  No / No |
| Where, on the inside and outside of home, does child like to play? / ¿Dónde le gusta jugar al niño, en el interior o el exterior del hogar? |
| Where do you think child is getting lead exposures? / ¿Dónde cree que el niño está expuesto al plomo? |
| Does your child have any health/medical/dental problems diagnosed by a doctor?  ¿El niño tiene algún problema de salud/medico/dental que haya sido diagnosticado por un medico?  Yes / Sí  No / No |

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| Does your child use utensils? / ¿El niño usa utensilios/cubiertos?  Yes / Sí  No / No | | | | | | | | | | | | | |
| Can your child feed him/herself? / ¿El niño se alimenta solo?  Yes / Sí  No / No | | | | | | | | | | | | | |
| Does your child have any food/drink allergies? / ¿El niño tiene alergia a alguna comida o bebida?  Yes / Sí  No / No | | | | | | | | | | | | | |
| Are you concerned about your child's eating habits? / ¿Le preocupa los hábitos alimenticios de su niño?  Yes / Sí  No / No | | | | | | | | | | | | | |
| What are particular food/drink items you child does NOT prefer to eat? *Please list.* / ¿Que comida o bebida en particular su niño prefiere NO comer? *Por favor haga una Iista.* | | | | | | | | | | | | | |
| Does your child take any of the following? / ¿Su hijo toma alguno de los siguientes medicamentos? | | | | | | | | | | | | | |
| Medications – *If so please list.* / Medicamentos – *Si es así, por favor menciónelos.* | | | | | | | |  | | | | |  |
| Vitamins / Vitaminas  Herbs / Herbias  Homemade Remedies / Remedios Caseros)  Supplements / Suplementos | | | | | | | | | | | | | |
| Other / Otro: |  | | | | | | | | | | | |  |
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| Do you have a working / ¿Funcicona su?  Stove Top / Estufa  Oven (Horno)  Microwave / Microonda  Refrigerator / Refrigerador | | | | | | | | | | | | | |
| Where does your child typically eat? / ¿Dónde suele comer su hijo? | | | | | | | | | | | | | |
| In a high chair / En una silla alta)  At the table / En la mesa  On the sofa / En el sofá  In a restaurant / En un restaurante | | | | | | | | | | | | | |
| In school / En la escuela  In the car / En el carro  At childcare / En la guardería  Head Start/preschool / Preescolar) | | | | | | | | | | | | | |
| With the TV on / Con la televisión encendida  With family and friends / Con la familia y amigos  Alone / Solo | | | | | | | | | | | | | |
| Other / Otro: |  | | | | | | | | | | | |  |
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| At meal times, how often does your child eat the same foods as the rest of the family? / En las comidas, ¿con que frecuencia come su hijo los mismos alimentos que el resto de la familia?  Most of the time / La mayor parte del tiempo  Sometimes / A veces  Rarely / Raramente  Never / Nunca | | | | | | | | | | | | | |
| What types of food does your child eat? / ¿Qué tipo de comida come su hijo? | | | | | | | | | | | | | |
| Breast/Bottle Only / Sólo amamantado/biberon  Baby Food / Comida de Bebe  Table Food / Comida de mesa | | | | | | | | | | | | | |
| Coarsely chopped/sliced / Picada/cortada en trozos)  Mashed/Blended / Pure/Mezclada  Finely Chopped / Picada finamente) | | | | | | | | | | | | | |
| Other / Otro: |  | | | | | | | | | | |  | |
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| How many times does your child eat each day? / ¿Cuántas veces come su niño a diario? | | | | | | | | | | | | | |
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|  | | Snacks / Bocadillos | |  | |  | Meals / Comidas: | | |  |  | | |
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| What snack foods does your child usually eat? / ¿Qué bocadillos suele comer su hijo? | | | | | | | | | | | | | |
| Fruit / Fruta  Fruit Snacks / Bocadillos de Fruta  Cookies/Snack Cakes / Galletas/Pastelitos  Crackers / Galletas | | | | | | | | | | | | | |
| Chips/Popcorn / Papas Fritas/Palomitas de Maíz  Nuts / Nueces  Pretzels / Galleta salada  Ice Cream / Helado | | | | | | | | | | | | | |
| Cereal / Cereal  Vegetables / Vegetales  Cheese / Queso  Yogurt / Yogur  Hard Candies / Dulces | | | | | | | | | | | | | |
| Soda/Pop / Soda  Raisins / Pasas  Other / Otro: | | | | |  | | | | | | | |  |
|  | | | | | | | | | | | | | |
| How many times does your child eat fruits and vegetables each day? / ¿Cuántas veces come su niño frutas y verduras a diario? | | | | | | | | | | | | | |
| What types of fruits and/or vegetables will your child eat? / ¿Qué tipos de frutas y vegetales come su hijo? | | | | | | | | | | | | | |
| Apples/Applesauce / Manzanas/Compota de manzana  Bananas / Plátanos  Grapes / Uvas  Oranges / Naranjas  Pears / Pera | | | | | | | | | | | | | |
| Potatoes / Papas  Squash / Chayote  French Fries / Papas Fritas  Corn / Maíz  Green Beans / Ejotes | | | | | | | | | | | | | |
| Carrots / Zanahorias Sprouts / Coles de Bruselas  Tomatoes / Tomates  Greens/Lettuce / Verdes/Lechuga  Onions / Cebolla | | | | | | | | | | | | | |
| Broccoli / Brócoli  Melons / Melones  Berries / Bayas  Other / Otro: | | | | | | | | |  | | | |  |
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| How many times does your child eat protein during a normal day? / ¿Cuántas veces come su hijo proteínas durante un día normal? | | | | | | | | | | | | | |
| Which protein rich foods will your child eat? / ¿Que alimentos ricos en proteínas comerá su hijo? | | | | | | | | | | | | | |
| Beef/Hamburgers / Carne de res/Hamburguesas  Venison / Venado  Chicken / Pollo  Turkey / Pavo | | | | | | | | | | | | | |
| Fish/Seafood / Pescado/Mariscos  Pork/Ham/Bacon / Cerdo/Jamón/tocino  Hot Dogs/Lunch Meat / Perros calientes/carne de almuerzo | | | | | | | | | | | | | |
| Yogurt / Yogur  Eggs / Huevos  Peanut Butter / Mantequilla de Maní  Tofu  Beans / Frijoles | | | | | | | | | | | | | |
| Cheese (Not pre-sliced or Velveeta) / Queso (En Rebanadas o Velveeta)  Cottage Cheese / Requesón | | | | | | | | | | | | | |
| Other / Otro: |  | | | | | | | | | | | |  |
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| What does your child drink from? / ¿De dónde bebe su hijo?  Breast / Pecho  Bottle / Mamila  Sippy Cup / Taza de Entrenamiento  Glass/Cup / Vaso de Vidrio | | | | | | | | | | | | | |
| What type of milk does your child usually drink? / ¿Que tipo de leche bebe su hijo normalmente? | | | | | | | | | | | | | |
| Whole (Vitamin D) / Entera (Vitamina D)  Reduced/Low Fat (2%, 1 % or ½ %) / Reducida/baja en grasa (2%, 1 % o ½%) | | | | | | | | | | | | | |
| Skim / Descremada  Lactose Free / Sin Lactosa  Goat Milk / Leche de Cabra  Evaporated Milk / Leche Evaporada | | | | | | | | | | | | | |
| Sweetened Condensed / Leche Condensada/Azucarada  Soy Milk / Leche de Soya  Rice Milk / Leche de Arroz | | | | | | | | | | | | | |
| Other / Otro: |  | | | | | | | | | | | |  |
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| How many cups of MILK does your child drink during a normal day? / ¿Cuántas tazas de LECHE bebe su hijo durante un día normal? | | | | | | | | | | | | | |
| How much MILK does your child drink each time? *(In ounces)* / ¿Cuánta LECHE bebe su hijo cada vez que lo hace? *(En ouzas)* | | | | | | | | | | | | | |
| Do you ever add flavoring to the child's milk? / ¿Alguna vez ha agregado saborizante a la leche del niño?  Yes / Sí  No / No | | | | | | | | | | | | | |
| What? / ¿Cual? | | | | | | | | | | | | | |
| How many cups of WATER does your child drink during a normal day? / ¿Cuántas tazas de AGUA bebe su hijo durante un día normal? | | | | | | | | | | | | | |
| How much WATER does your child drink each time? *(In ounces)* / ¿Cuánta AGUA bebe su hijo cada vez que lo hace? *(En ouzas)* | | | | | | | | | | | | | |
| What kind of water does your child usually drink? / ¿Qué tipo de agua suele beber su hijo? | | | | | | | | | | | | | |
| City / De Ciudad  Rural / Rural  Well / De Pozo  Bottled / Embotellada  Filtered / Filtrada | | | | | | | | | | | | | |
| Unsure / No esta segura  Other / Otra: | | |  | | | | | | | | | |  |
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| How many cups of JUICE does your child drink during a normal day? / ¿Cuántas tazas de JUGO bebe su hijo durante un día normal? | | | | | | | | | | | | | |
| How much JUICE does your child drink each time? *(In ounces)* / ¿Cuánta JUGO bebe su hijo cada vez que lo hace? *(En ouzas)* | | | | | | | | | | | | | |
| Do you dilute the juice with water? / ¿Diluye el jugo con agua?  Yes / Sí  No / No | | | | | | | | | | | | | |

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| ***FOR ADMINISTRATIVE USE ONLY.*** |

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| **REFERRALS** | | | |
|  | **YES or NO** | **AGENCY** | **DATE *(month, day, year)*** |
| Was a referral made for developmental assessment? |  |  |  |
| Was a referral made for nutritional assessment? |  |  |  |
| Was a referral made to WIC? |  |  |  |
| Was a referral made to Head Start? |  |  |  |

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| **NOTES** |
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| ***Please check the specific event code(s) that occurred in this case and record the date.*** | | | |
| **Result Codes: C** - Complete; **L** - Could Not Locate; **M** - Moved; **N** - No One Home; **O** - Incomplete, Other; **R** - Refused | | | |
| **Event Code** | **Event Description** | **Date Completed *(month, day, year)*** | **Result Code** |
| 0CNTP | Contact Attempt by Telephone |  |  |
| 0CNTL | Contact Attempt by Letter |  |  |
| 0IHVN | Initial Home Visit by Public Health Nurse |  |  |
| 0IHVC | Initial Home Visit by Case Manager |  |  |
| 0HVED | Home Visit for Lead Education |  |  |
| 0HVOT | Home Visit for Any Other Reason |  |  |
| 0MIRO | Referred for Iron Deficiency |  |  |
| 0MCHI | Chelation, Inpatient |  |  |
| 0MCHO | Chelation, Outpatient |  |  |
| 0RFRA | Referred to Licensed Risk Assessor |  |  |
| 0HVRA | Risk Assessment Completed |  |  |
| 0HVDA | Developmental Assessment Conducted |  |  |
| 0DARF | Referral for Developmental Assessment |  |  |
| 0HDST | Headstart Participant |  |  |
| 0HSRF | Referral for Headstart Services |  |  |
| 0WICP | WIC Participant |  |  |
| 0WICR | WIC Referral |  |  |
| 0HVNA | Nutritional Assessment Conducted |  |  |
| 0NARF | Referral for Nutritional Assessment |  |  |

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| Completed by: *(Please print.)* | Date *(month, day, year)* |