Warren County Health Services
Child Health Program
301 North Buxton, Suite 203
Indianola, IA 50125
(515)-961-1074

Developmental Testing-ASQ 3

Child's Name: Date of Birth:	Medicaid Number: FFS UHC Amerigroup IA Total Care Hawki Private Insurance
Address: City: Zip:	Home Phone: Cell Phone:
Sex: M/F	Parent/Guardian Name:
Physician: Last Visit: Immunizations Current: **Y N**	Dentist: Last Visit:
Hispanic/Latino: yes/no	Race: American Indian/Alaskan Native Asian White Black or African American Native Hawaiian/Other Pacific Islander
Allergies:	Medications:

Child's Chronological Age: _____ **Child's Adjusted Age**: _____(if under 2 yrs of age and born more than 3 weeks premature, subtract # weeks premature from child's current age)

ASQ History: List Ages of Previously Completed ASQs: _____

Has the child ever been told that they have or had a developmental delay or disability?
(ex: delays in speech, crawling, or walking) Yes No

If Yes, Describe: _____

Does the child currently have or have they had a medical condition such as feeding/eating difficulties, lead exposure, or was the child born prematurely? Yes No

If yes explain: _____

Currently working with Early Access or AEA: Yes No **Does child have an IFSP:** Yes No

Currently working with any family support programs (ie: PAT, LSI, etc): Yes No

If yes list: _____

Parental Concerns:_____

Results: (see attached copy of ASQ Information Summary)

Results of developmental screen shared with primary care physician (release signed) Yes No

Referrals/Plan:

__No Referrals needed at this time
__Early Access 0-3yrs/AEA 3-5 years
__ 1st Five
__Other_____

Date of next recommended screening: _____(TAV entry: 1st of recommended month if no concerns; 15 of month if concerns identified)

Interpretation of Results:

_____
_____
_____
_____
_____
_____
_____

The results of the developmental screening have been explained to me. I have been given the opportunity to ask questions.

Parent/Guardian Signature: _____Date:_____

First and Last Name and Credentials of Person Performing Service:_____

Signature of Person Performing Service: _____ Date: _____

Time in: _____ Time out: _____ Location Where Service Performed:_____

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Lead Screening

Child's Name: Date of Birth:	Medicaid Number: FFS UHC Amerigroup IA Total Care Hawki Private Insurance
Address: City: Zip:	Home Phone: Cell Phone:
Sex: M/F	Parent/Guardian Name:
Physician: Last Visit: Immunizations Current: **Y N**	Dentist: Last Visit:
Hispanic/Latino: yes/no	Race: American Indian/Alaskan Native Asian White Black or African American Native Hawaiian/Other Pacific Islander
Allergies:	Medications:

Blood Lead Level:_____ Capillary (Lead Care II) or Venous **hgb:**_____

Lead Education Brochures Provided*: LP C PRO

*education: LP-Lead Poisoning: Has Your Child Been Tested, C-Your Child's Capillary Blood Level and What it Means, PRO: Lead Poisoning: How to Protect Iowa Families

Parental Concerns:_____

Discussed with parent/guardian: Any history of high lead levels (15 µg/dL or higher) in child/sibling/playmate?

Yes No Unknown Comments_____

Has the child ever been told that they have or had a developmental delay or disability? (ex: delays in speech, crawling, or walking) Yes No

If Yes, Describe:_____

Education

Lead Exposures:

___Older homes with peeling/chipping paint ___Soil ___Lead pipes ___Home or folk remedies

___Other: occupational/proximity to battery plants/lead smelters, candy from Mexico, travel

Ways to Reduce Lead Exposures: ___handwashing ___removal of shoes inside ___balanced diet with iron and calcium sources

___letting tap water used for drinking/cooking run cold prior to use

Benefits of Routine Screening: ___reducing risk of health and developmental/behavioral concerns caused by elevated lead levels

Explained Lead Results and Recommend Retest :

____ 1 year (lead level <10 micrograms/dL) ___ 6 months (age 18 mo., lead level <10micrograms/dL)

____ 6-12 months (lead level 5-9 micrograms/dL) ___ Additional education provided

____3 months (lead level 10-14 micrograms/dL) refer to Lead Case Manager

If Capillary Blood Lead Level is 15 micrograms/dL or higher:

Must have **Venous** Follow Up Lead Test: Refer to Lead Case Manager

___1 month (blood level 15-19 micrograms/dL) ___1 week (blood level 20-44 micrograms/dL)

___48 hours (blood level 45-69 micrograms/dL) ___Immediately (blood level is 70 micrograms/dL)

Summary of Services: _____

_____

_____

_____

The result of the lead test has been explained to me. I have been given the opportunity to ask questions.

Parent/Guardian Signature: _____Date:_____

First, Last Name and Credentials of Person Performing Service: _____

Signature of Person Performing Service: _____ Date: _____

Lead Analysis- Time in: _____ Time out: _____ Location Where Service Performed:_____

E & M- Time in: _____ Time Out:_____

Date Results Sent to Physician: _____