IOWA | Health and Human Services

Developmental Testing – ASQ 3

Child's Name: Date of Birth:	Medicaid Number: FFS Wellpoint Molina IA Total Care Hawki Private Insurance
Address: City: Zip:	Home Phone: Cell Phone:
Sex: M / F	Parent/Guardian Name:
Physician: Last Visit: Immunizations Current: **Yes No**	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 years 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 (i.e., 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

___Other

Date of next recommended screening: _____

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 Wellpoint Molina IA Total Care Hawki Private Insurance
Address: City: Zip:	Home Phone: Cell Phone:
Sex: M / F	Parent/Guardian Name:
Physician: Last Visit: Immunizations Current: **Yes No**	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 Other_____
**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 the risk of health and developmental/ behavioral concerns caused by elevated lead levels

Explained Lead Results and Recommended 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: _____