

## LEAD EXPOSURE RISK ASSESSMENT QUESTIONNAIRE

**PRIVACY ACT STATEMENT:**

Authority: 5 U.S.C. 301, Departmental Regulations; 10 U.S.C. 1095, Collection from Third Party Payers Act; 10 U.S.C. 5131 (as amended); 10 U.S.C. 5132; 44 U.S.C. 3101; and E.O. 9397 (SSN).

Purpose: Used by official, employees and contractors of the Department of the Navy (and members of the National Red Cross in naval medical treatment facilities) in the performance of their official duties relating to the health and medical treatment of Navy and Marine Corps members; research studies and compilation of statistical data; implementation of preventive medicine programs and occupational health surveillance programs.

Use: By medical professionals in the performance of official duties. Administrative/Web personnel will have access for purposes of maintaining the data base and inclusion into the medical record.

Disclosure: Disclosure of the requested information is voluntary; however, non disclosure may result in an inability to document medical records.

**1. Child Information**

a. Name	b. Date of Birth <i>(DD MMM YYYY)</i>
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**2. Address Information**

a. Street			
b. City	c. State	d. ZIP Code	
e. Housing Area or Subdivision		f. Address Type <input type="checkbox"/> Military <input type="checkbox"/> Nonmilitary	

**3. Does your child: *(Select one answer for each question)***

a. Live in a house that was built before 1950?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
b. Live in or regularly visit a house, day care center, or preschool that was built before 1980 which has peeling or chipping paint, or is undergoing renovation or remodeling?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
c. Have a brother, sister, housemate, or playmate who has or once had lead poisoning or a high blood lead level?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
d. Live or spend time with someone whose job or hobbies involve exposure to lead (examples: reloading ammunition, making fishing weights, making ceramics, making stained glass, working at a firing range, working with industrial or shipboard paint removal, working with electrical or torch soldering, making soft metal castings)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
e. Live or spend time near any location that you think might release lead (lead smelter, radiator shop, battery recycler, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
f. Live in or regularly visit a house, day care center, or preschool that was identified by a DoD inspection team as a major risk for lead?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know
g. Use, play with, or used to play with a toy or other object that was recalled or identified as having high-lead paint?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

**4. Medical Treatment Facility:**

If the child is "high risk" (i.e., if any answer is "yes" or any "don't know" answer is determined by a physician to be "yes"), forward a copy of this form with the blood lead level result to Preventive Medicine. Provide the child's parent or guardian with a note (see Web site: <http://www.cdc.gov/nceh/lead/lead.htm> for guidance) indicating potential exposure to lead.

Completed By Name	Signature	Date
Reviewed By Name	Signature	Date

Patient Identification *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; DOB; Rank/Grade.)*

Hospital or Medical Facility
Sponsor's Name
SSN/ID No.