



18 Month Questionnaire

17 months 0 days
through 18 months 30 days

On the following pages are questions about activities children may do. Your child may have already done some of the activities described here, and there may be some your child has not begun doing yet. For each item, please fill in the circle that indicates whether your child is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your child before marking a response.
- Make completing this questionnaire a game that is fun for you and your child.
- Make sure your child is rested and fed.
- Please return this questionnaire by _____.

Notes:

At this age, many toddlers may not be cooperative when asked to do things. You may need to try the following activities with your child more than one time. If possible, try the activities when your child is cooperative. If your child can do the activity but refuses, mark "yes" for the item.

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. When your child wants something, does she tell you by <i>pointing</i> to it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
2. When you ask your child to, does he go into another room to find a familiar toy or object? (You might ask, "Where is your ball?" or say, "Bring me your coat," or "Go get your blanket.")	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
3. Does your child say eight or more words in addition to "Mama" and "Dada"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
4. Does your child imitate a two-word sentence? For example, when you say a two-word phrase, such as "Mama eat," "Daddy play," "Go home," or "What's this?" does your child say both words back to you? (Mark "yes" even if her words are difficult to understand.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
5. Without your showing him, does your child <i>point</i> to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" (He needs to identify only one picture correctly.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
6. Does your child say two or three words that represent different ideas together, such as "See dog," "Mommy come home," or "Kitty gone"? (Don't count word combinations that express one idea, such as "bye-bye," "all gone," "all right," and "What's that?") Please give an example of your child's word combinations:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

COMMUNICATION TOTAL _____

GROSS MOTOR

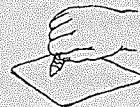
- 1. Does your child bend over or squat to pick up an object from the floor and then stand up again without any support?
- 2. Does your child move around by walking, rather than by crawling on her hands and knees?
- 3. Does your child walk well and seldom fall?
- 4. Does your child climb on an object such as a chair to reach something he wants (for example, to get a toy on a counter or to "help" you in the kitchen)?
- 5. Does your child walk down stairs if you hold onto one of her hands? She may also hold onto the railing or wall. (You can look for this at a store, on a playground, or at home.)
- 6. When you show your child how to kick a large ball, does he try to kick the ball by moving his leg forward or by walking into it? (If your child already kicks a ball, mark "yes" for this item.)



YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
GROSS MOTOR TOTAL			—

FINE MOTOR

- 1. Does your child throw a small ball with a forward arm motion? (If he simply drops the ball, mark "not yet" for this item.)
- 2. Does your child stack a small block or toy on top of another one? (You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)
- 3. Does your child make a mark on the paper with the tip of a crayon (or pencil or pen) when trying to draw?
- 4. Does your child stack three small blocks or toys on top of each other by himself?
- 5. Does your child turn the pages of a book by himself? (He may turn more than one page at a time.)
- 6. Does your child get a spoon into her mouth right side up so that the food usually doesn't spill?



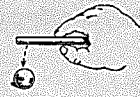
YES	SOMETIMES	NOT YET	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
FINE MOTOR TOTAL			—

PROBLEM SOLVING

1. Does your child drop several small toys, one after another, into a container like a bowl or box? (You may show him how to do it.)

YES SOMETIMES NOT YET _____

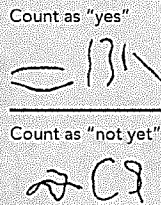
2. After you have shown your child how, does she try to get a small toy that is slightly out of reach by using a spoon, stick, or similar tool?



3. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle over to dump it out? (You may show him how.) (You can use a soda-pop bottle or a baby bottle.)

4. Without your showing her how, does your child scribble back and forth when you give her a crayon (or pencil or pen)?

5. After watching you draw a line from the top of the paper to the bottom with a crayon (or pencil or pen), does your child copy you by drawing a single line on the paper in any direction? (Mark "not yet" if your child scribbles back and forth.)



6. After a crumb or Cheerio is dropped into a small, clear bottle, does your child turn the bottle upside down to dump out the crumb or Cheerio? (Do not show him how.)

_____ *

PROBLEM SOLVING TOTAL _____
 *If Problem Solving Item 6 is marked "yes" or "sometimes," mark Problem Solving Item 3 "yes."

PERSONAL-SOCIAL

1. While looking at herself in the mirror, does your child offer a toy to her own image?

YES SOMETIMES NOT YET _____

2. Does your child play with a doll or stuffed animal by hugging it?

3. Does your child get your attention or try to show you something by pulling on your hand or clothes?

4. Does your child come to you when he needs help, such as with winding up a toy or unscrewing a lid from a jar?

5. Does your child drink from a cup or glass, putting it down again with little spilling?

6. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?

PERSONAL-SOCIAL TOTAL _____

OVERALL

Parents and providers may use the space below for additional comments.

1. Do you think your child hears well? If no, explain:

YES

NO

2. Do you think your child talks like other toddlers his age? If no, explain:

YES

NO

3. Can you understand most of what your child says? If no, explain:

YES

NO

4. Do you think your child walks, runs, and climbs like other toddlers her age?
If no, explain:

YES

NO

5. Does either parent have a family history of childhood deafness or hearing
impairment? If yes, explain:

YES

NO

6. Do you have concerns about your child's vision? If yes, explain:

YES

NO

OVERALL (continued)

7. Has your child had any medical problems in the last several months? If yes, explain:

 YES NO

8. Do you have any concerns about your child's behavior? If yes, explain:

 YES NO

9. Does anything about your child worry you? If yes, explain:

 YES NO



18 Month ASQ-3 Information Summary

17 months 0 days through
18 months 30 days

Child's name: _____ Date ASQ completed: _____
 Child's ID #: _____ Date of birth: _____
 Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.06		●	●	●	○	○	○	○	○	○	○	○	○	○
Gross Motor	37.38		●	●	●	●	●	●	●	○	○	○	○	○	○
Fine Motor	34.32		●	●	●	●	●	●	○	○	○	○	○	○	○
Problem Solving	25.74		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	27.19		●	●	●	●	●	○	○	○	○	○	○	○	○

2. **TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|--|-----|------------|--|------------|----|
| 1. Hears well?
Comments: | Yes | NO | 6. Concerns about vision?
Comments: | YES | No |
| 2. Talks like other toddlers his age?
Comments: | Yes | NO | 7. Any medical problems?
Comments: | YES | No |
| 3. Understand most of what your child says?
Comments: | Yes | NO | 8. Concerns about behavior?
Comments: | YES | No |
| 4. Walks, runs, and climbs like other toddlers?
Comments: | Yes | NO | 9. Other concerns?
Comments: | YES | No |
| 5. Family history of hearing impairment?
Comments: | | YES | No | | |

3. **ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

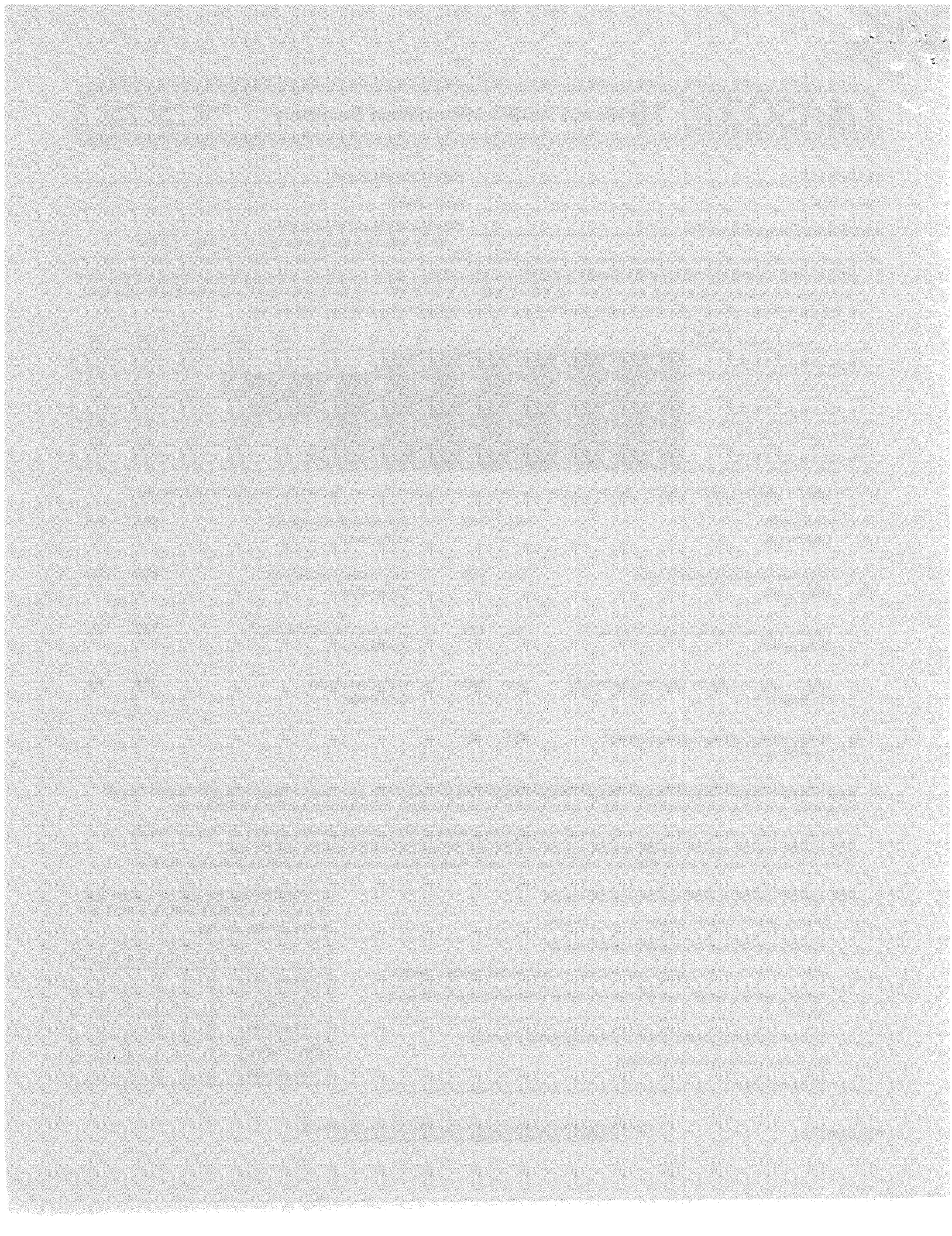
If the child's total score is in the area, it is above the cutoff, and the child's development appears to be on schedule.
 If the child's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
 If the child's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. **FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. **OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim
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❁ 18 Month ❁
Questionnaire

(For children ages 15 through 20 months)



Important Points to Remember:

- Please return this questionnaire by _____ .
- If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- Thank you and please look forward to filling out another ASQ:SE questionnaire in _____ months.



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About the Authors	
ASQ Training	TK
ASQ Ordering Guide	TK
End User License Agreement	TK

Please read each question carefully and

1. Check the box that best describes your child's behavior *and*
2. Check the circle if this behavior is a concern

MOST
OF THE
TIME

SOMETIMES

RARELY
OR
NEVER

CHECK IF
THIS IS A
CONCERN

1. Does your child look at you when you talk to him?

 z

 v

 x

2. When you leave, does your child remain upset and cry for more than an hour?

 x

 v

 z

3. Does your child laugh or smile when you play with her?


 z

 v

 x

4. Does your child look for you when a stranger approaches?

 z

 v

 x

5. Is your child's body relaxed?

 z

 v

 x

6. Does your child like to be hugged or cuddled?

 z

 v

 x

7. When upset, can your child calm down within 15 minutes?

 z

 v

 x

8. Does your child stiffen and arch his back when picked up?

 x

 v

 z

9. Does your child cry, scream, or have tantrums for long periods of time?

 x

 v

 z

TOTAL POINTS ON PAGE —

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>

TOTAL POINTS ON PAGE ____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child let you know how she is feeling with gestures or words? For example, does she let you know when she is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child like to play near or be with family members and friends?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child like to hear stories or sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child like to be around other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>



TOTAL POINTS ON PAGE —

MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
------------------------	-----------	-----------------------	----------------------------------

26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:

x v z

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

28. Is there anything that worries you about your child? If so, please explain:

29. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ____

18 Month ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____
 Person filling out the ASQ:SE: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ:SE completion: _____
 Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box = 0 points
 V (for Roman numeral V) next to the checked box = 5 points
 X (for Roman numeral X) next to the checked box = 10 points
 Checked concern = 5 points

Add together:

Total points on page 3 = _____
 Total points on page 4 = _____
 Total points on page 5 = _____
 Total points on page 6 = _____

Child's total score = _____

SCORE INTERPRETATION

1. Review questionnaires

Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.

2. Transfer child's total score

In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
18 months	50	

3. Referral criteria

Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.

4. Referral considerations

It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.

- Setting/time factors
(e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
- Development factors
(e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
- Health factors
(e.g., Is the child's behavior related to health or biological factors?)
- Family/cultural factors
(e.g., Is the child's behavior acceptable given cultural or family context?)



Child's name _____
Age _____

Date _____
Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle **yes** or **no** for every question. Thank you very much.

- | | | |
|--|-----|----|
| 1. If you point at something across the room, does your child look at it?
(FOR EXAMPLE , if you point at a toy or an animal, does your child look at the toy or animal?) | Yes | No |
| 2. Have you ever wondered if your child might be deaf? | Yes | No |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE , pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | Yes | No |
| 4. Does your child like climbing on things? (FOR EXAMPLE , furniture, playground equipment, or stairs) | Yes | No |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?
(FOR EXAMPLE , does your child wiggle his or her fingers close to his or her eyes?) | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help?
(FOR EXAMPLE , pointing to a snack or toy that is out of reach) | Yes | No |
| 7. Does your child point with one finger to show you something interesting?
(FOR EXAMPLE , pointing to an airplane in the sky or a big truck in the road) | Yes | No |
| 8. Is your child interested in other children? (FOR EXAMPLE , does your child watch other children, smile at them, or go to them?) | Yes | No |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE , showing you a flower, a stuffed animal, or a toy truck) | Yes | No |
| 10. Does your child respond when you call his or her name? (FOR EXAMPLE , does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | Yes | No |
| 11. When you smile at your child, does he or she smile back at you? | Yes | No |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE , does your child scream or cry to noise such as a vacuum cleaner or loud music?) | Yes | No |
| 13. Does your child walk? | Yes | No |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | Yes | No |
| 15. Does your child try to copy what you do? (FOR EXAMPLE , wave bye-bye, clap, or make a funny noise when you do) | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | Yes | No |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE , does your child look at you for praise, or say “look” or “watch me”?) | Yes | No |
| 18. Does your child understand when you tell him or her to do something?
(FOR EXAMPLE , if you don't point, can your child understand “put the book on the chair” or “bring me the blanket”?) | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it?
(FOR EXAMPLE , if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities?
(FOR EXAMPLE , being swung or bounced on your knee) | Yes | No |



PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider: _____	Phone: _____	Date: _____
-----------------------------------	--------------	-------------

Child's Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ County: _____

Sex: Male Female Hispanic: No Yes Race: White Black Asian Am. Indian/Nat. Alaskan Other _____

US Born: Yes No If no, US Date of Arrival: ____/____/____ Country of Birth: _____

Parent/Guardian: _____ Phone: _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of country: _____
6. Is the child exposed to a person who: <ul style="list-style-type: none"> • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.

MEDICAL INFORMATION:

Primary Reason for Evaluation: Contact Investigation Targeted Testing Immigration Exam
 Incidental Abnormal CXR/CT Incidental Lab Result
 Other: _____

Symptomatic: No Yes If Yes, ONSET date: ____/____/____

Symptoms: Cough Hemoptysis Fever Night Sweats Weight Loss of ____ lbs.
 Other: _____

Tuberculin Skin Test (TST/Mantoux/PPD) Date Given: ____/____/____ Date Read: ____/____/____	Induration: _____ mm Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Interferon Gamma Release Assay (IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Chest X-ray (required with positive TST or IGRA) Date: ____/____/____	Impression: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal findings
<input type="checkbox"/> LTBI treatment (Rx and start date): Rx: _____ Date: ____/____/____ <input type="checkbox"/> Contraindications to INH or rifampin for LTBI	<input type="checkbox"/> Prior TB/LTBI treatment (Rx and duration): Rx: _____ _____ mm <input type="checkbox"/> Offered but refused LTBI treatment

ADDITIONAL COMMENTS:

RECOMMENDATIONS:

Health Provider Signature: _____ Date Completed: ____/____/____



Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:

All children 6 years of age or younger must be evaluated for lead exposure.

All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test *must* be obtained.
- If there are any "YES" or "DON'T KNOW" answers *and*
 - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
 - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
 - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Child's name _____ Today's date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.

RESPONSE

- | | | | |
|--|-----|----|------------|
| 1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area?
(see reverse side of page for high risk ZIP code area list) | Yes | No | Don't Know |
| 2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program?

***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed. | Yes | No | Don't Know |
| 3. Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978? | Yes | No | Don't Know |
| 5. Is this child a refugee, adoptee, or recent visitor of any foreign country? | Yes | No | Don't Know |
| 6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)? | Yes | No | Don't Know |
| 7. Does this child live with someone who has a job or a hobby that may involve lead (for example; jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)? | Yes | No | Don't Know |
| 8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)? | Yes | No | Don't Know |
| 10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? | Yes | No | Don't Know |

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.
Fax: 217-557-1188 Phone: 866-909-3572**

Signature of Doctor/Nurse

Date

**Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466**



Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams 62301 62320 62324 62339 62346 62348 62349 62365	Christian 62083 62510 62517 62540 62546 62555 62556 62557 62567 62570	DuPage 60519 Edgar 61917 61924 61932 61933 61940 61944 61949	Grundy 60437 60474 Hamilton 62817 62828 62829 62859	Jefferson 62883 Jersey 62030 62063 Jo Daviess 61028 61075 61085 61087	Livingston 60420 60460 60920 60921 60929 60934 61311 61313 61333 61740 61741 61743 61769 61775	Massac 62953 McDonough 61411 61416 61420 61422 61438 61440 61470 61475 62374	Peoria 61451 61529 61539 61552 61602 61603 61604 61605 61606 Perry 62319 62832 62997	Saline 62930 62946 Sangamon 62625 62689 62703 Schuyler 61452 62319 62344 62624 62639	Warren 61412 61417 61423 61435 61447 61453 61462 61473 61478 Washington 62214 62803 Wayne 62446 62823 62843 62886 White 62820 62821 62835 62844 62887 Whiteside 61037 61479 61483 61251 61261 61270 61277 61283 Will 60432 60433 60436 Williamson 62921 62948 62949 62951 Winnebago 61077 61101 61102 61103 61104 Woodford 61516 61545 61570 61760			
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