ASQ-3 Ages & Stages Questionnaires®

23 months 0 days through 25 months 15 days

24 Month Questionnaire

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Child's information

Child's first name:

Middle initial:

Child's last name:

Child's date of birth: M M D D Y Y Y Y

Child's gender: ◯ Male ◯ Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to child: ◯ Parent ◯ Guardian ◯ Teacher ◯ Child care provider ◯ Grandparent or other relative ◯ Foster parent ◯ Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Child ID #:

Program ID #:

Program name:

E101240100

ASQ-3

24 Month Questionnaire

23 months 0 days through 25 months 15 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. Without your showing him, does your child *point* to the correct picture when you say, "Show me the kitty," or ask, "Where is the dog?" *(She needs to identify only one picture correctly.)*	◯	◯	◯	____
2. 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.)*	◯	◯	◯	____
3. Without your giving him clues by pointing or using gestures, can your child carry out at least *three* of these kinds of directions?	◯	◯	◯	____
◯ a. "Put the toy on the table." ◯ d. "Find your coat."				
◯ b. "Close the door." ◯ e. "Take my hand."				
◯ c. "Bring me a towel." ◯ f. "Get your book."				
4. If you point to a picture of a ball (kitty, cup, hat, etc.) and ask your child, "What is this?" does your child correctly *name* at least one picture?	◯	◯	◯	____
5. 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:	◯	◯	◯	____

COMMUNICATION *(continued)*

	YES	SOMETIMES	NOT YET	
6. Does your child correctly use at least two words like "me," "I," "mine," and "you"?	○	○	○	___

COMMUNICATION TOTAL ___

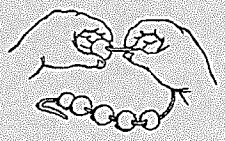
GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. 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.)*	○	○	○	___
2. 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.)* 	○	○	○	___
3. Does your child walk either up or down at least two steps by herself? She may hold onto the railing or wall. 	○	○	○	___
4. Does your child run fairly well, stopping herself without bumping into things or falling? 	○	○	○	___
5. Does your child jump with both feet leaving the floor at the same time? 	○	○	○	___
6. Without holding onto anything for support, does your child kick a ball by swinging his leg forward? 	○	○	○	___ *

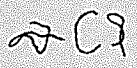
GROSS MOTOR TOTAL ___

**If Gross Motor Item 6 is marked "yes" or "sometimes," mark Gross Motor Item 2 "yes."*

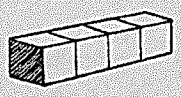
FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your child get a spoon into his mouth right side up so that the food usually doesn't spill?	○	○	○	___
2. Does your child turn the pages of a book by herself? *(She may turn more than one page at a time.)*	○	○	○	___
3. Does your child use a turning motion with his hand while trying to turn doorknobs, wind up toys, twist tops, or screw lids on and off jars?	○	○	○	___
4. Does your child flip switches off and on?	○	○	○	___
5. Does your child stack seven small blocks or toys on top of each other by herself? *(You could also use spools of thread, small boxes, or toys that are about 1 inch in size.)*	○	○	○	___
6. Can your child string small items such as beads, macaroni, or pasta "wagon wheels" onto a string or shoelace? 	○	○	○	___
			FINE MOTOR TOTAL	___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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.)* Count as "yes"  Count as "not yet" 	○	○	○	___
2. 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.) (You can use a soda-pop bottle or baby bottle.)*	○	○	○	___
3. Does your child pretend objects are something else? For example, does your child hold a cup to her ear, pretending it is a telephone? Does she put a box on her head, pretending it is a hat? Does she use a block or small toy to stir food?	○	○	○	___
4. Does your child put things away where they belong? For example, does he know his toys belong on the toy shelf, his blanket goes on his bed, and dishes go in the kitchen?	○	○	○	___
5. If your child wants something she cannot reach, does she find a chair or box to stand on to reach it (for example, to get a toy on a counter or to "help" you in the kitchen)?	○	○	○	___

PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. While your child watches, line up four objects like blocks or cars in a row. Does your child copy or imitate you and line up *four* objects in a row? *(You can also use spools of thread, small boxes, or other toys.)* 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your child drink from a cup or glass, putting it down again with little spilling?	○	○	○	___
2. Does your child copy the activities you do, such as wipe up a spill, sweep, shave, or comb hair?	○	○	○	___
3. Does your child eat with a fork?	○	○	○	___
4. When playing with either a stuffed animal or a doll, does your child pretend to rock it, feed it, change its diapers, put it to bed, and so forth?	○	○	○	___
5. Does your child push a little wagon, stroller, or other toy on wheels, steering it around objects and backing out of corners if he cannot turn?	○	○	○	___
6. Does your child call herself "I" or "me" more often than her own name? For example, "I do it," more often than "Juanita do it."	○	○	○	___

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 her age? If no, explain: ○ YES ○ NO

E101240500

OVERALL *(continued)*

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 his 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 any concerns about your child's vision? If yes, explain: ○ YES ○ NO

7. Has your child had any medical problems in the last several months? If yes, explain: ○ YES ○ NO

OVERALL *(continued)*

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

ASQ-3 24 Month ASQ-3 Information Summary

23 months 0 days through 25 months 15 days

Child's name: _____ Date ASQ completed: _____

Child's ID #: _____ Date of birth: _____

Administering program/provider: _____

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	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

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

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

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						

P101240800

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**

ASQ:SE™

24 Month/2 Year Questionnaire

(For children ages 21 through 26 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.

ASQ:SE™

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
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24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE™

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. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	○
3. Does your child laugh or smile when you play with her?	❑ z	❑ v	❑ x	○
4. Is your child's body relaxed?	❑ z	❑ v	❑ x	○
5. When you leave, does your child remain upset and cry for more than an hour? 	❑ x	❑ v	❑ z	○
6. Does your child greet or say hello to familiar adults?	❑ z	❑ v	❑ x	○
7. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	○
8. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	○
9. Does your child stiffen and arch his back when picked up?	❑ 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?	☐ z	☐ v	☐ x	○
11. Does your child cry, scream, or have tantrums for long periods of time?	☐ x	☐ v	☐ z	○
12. Do you and your child enjoy mealtimes together?	☐ z	☐ v	☐ x	○
13. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	☐ x	☐ v	☐ z	○
14. Does your child sleep at least 10 hours in a 24-hour period?	☐ z	☐ v	☐ x	○
15. When you point at something, does your child look in the direction you are pointing?	☐ z	☐ v	☐ x	○
16. Does your child have trouble falling asleep at naptime or at night?	☐ x	☐ v	☐ z	○
17. Does your child get constipated or have diarrhea?	☐ x	☐ v	☐ z	○
18. Does your child follow simple directions? For example, does he sit down when asked?	☐ z	☐ v	☐ x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?	☐ z	☐ v	☐ x	○
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	☐ z	☐ v	☐ x	○
21. 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.)	☐ x	☐ v	☐ z	○
22. Does your child like to hear stories or sing songs? 	☐ z	☐ v	☐ x	○
23. Does your child hurt himself on purpose?	☐ x	☐ v	☐ z	○
24. Does your child like to be around other children? 	☐ z	☐ v	☐ x	○
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ x	☐ v	☐ z	○

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 ___

24 Month/2 Year 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
24 months/2 years	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?)

M-CHAT

www.m-chat.org

Child's name _____ Date _____

Age _____ 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 unusual 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

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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?	❒Yes ❒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?	❒Yes ❒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?	❒Yes ❒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?	❒Yes ❒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?	❒Yes ❒No	If yes, name of country: _____
6. Is the child exposed to a person who: • 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?	❒Yes ❒No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	❒Yes ❒No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❒Yes ❒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:** ❒Negative ❒Positive
Interferon Gamma Release Assay (IGRA) **Date:** _____/_____/_____	**Impression:** ❒Negative ❒Positive ❒Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date:** _____/_____/_____	**Impression:** ❒Normal ❒Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:_____ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: _____ _____mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

_____

_____

_____

_____

RECOMMENDATIONS:

_____

_____

_____

_____

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

State of Illinois
Illinois Department of Public Health

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

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State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago
ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

DeWitt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
61477
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61501
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61524
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61543
61544
61563

Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

Hancock
61450
62311
62313
62316
62318
62321
62330
62334
62336
62354
62367
62373
62379
62380

Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
61235
61238
61274
61413
61419
61434
61443
61468
61490

Iroquois
60911
60912
60924
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Jackson
62927
62940
62950

Jasper
62432
62434
62459
62475
62480

Jefferson
62883
Jersey
62030
62063

Jo Daviess
61028
61075
61085
61087

Johnson
62908
62923
Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
61410
61414
61436
61439
61458
61467
61474
61485
61489
61572

Lake
60040

LaSalle
60470
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61301
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Lawrence
62439
62460
62466

Lee
60553
61006
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Livingston
60420
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Logan
62512
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62643
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Macon
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Macoupin
62009
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62069
62085
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62093
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62649
62672
62674
62685
62686
62690

Madison
62002
62048
62058
62060
62084
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62095

Marion
None

Marshall
61369
61377
61424
61537
61541

Mason
62617
62633
62644
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62664
62682

Massac
62953

McDonough
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McHenry
60034

McLean
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Menard
62642
62673
62688

Mercer
61231
61260
61263
61276
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61466
61476
61486

Monroe
None

Montgomery
62015
62019
62032
62049
62051
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62094
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Morgan
62601
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62695

Moultrie
61937

Ogle
61007
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Peoria
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Perry
62832
62997

Piatt
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61929
61936

Pike
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62323
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62343
62345
62352
62355
62356
62357
62361
62362
62363
62366
62370

Pope
None

Pulaski
62956
62963
62964
62976
62992

Putnam
61336
61340
61363

Randolph
62217
62242
62272

Richland
62419
62425

Rock Island
61201
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St. Clair
62201
62203
62204
62205
62220
62289

Saline
62930
62946

Sangamon
62625
62689
62703

Schuyler
61452
62319
62344
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Scott
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Shelby
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Stark
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Stephenson
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Tazewell
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Union
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Vermilion
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Wabash
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Warren
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Washington
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Wayne
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White
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Whiteside
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Will
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60433
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Williamson
62921
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62951

Winnebago
61077
61101
61102
61103
61104

Woodford
61516
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