ASQ-3™ Ages & Stages Questionnaires®

5 months 0 days through 6 months 30 days

6 Month Questionnaire

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

Date ASQ completed: _____

Baby's information

Baby's first name: _____ Middle initial: _____ Baby's last name: _____

Baby's date of birth: _____

If baby was born 3 or more weeks prematurely, # of weeks premature: _____

Baby's gender:
◯ Male ◯ Female

Person filling out questionnaire

First name: _____ Middle initial: _____ Last name: _____

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

Street address: _____

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

Baby ID #: _____ Age at administration in months and days: _____

Program ID #: _____ If premature, adjusted age in months and days: _____

Program name: _____

P101060100

ASQ-3™

6 Month Questionnaire

5 months 0 days through 6 months 30 days

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

Important Points to Remember:

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

Notes:

_____

_____

_____

_____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	○	○	○	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	○	○	○	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	○	○	○	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	○	○	○	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	○	○	○	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	○	○	○	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	○	○	○	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	○	○	○	___
4. When you put your baby on the floor, does she lean on her hands while sitting? *(If she already sits up straight without leaning on her hands, mark "yes" for this item.)* 	○	○	○	___

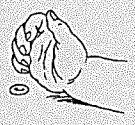
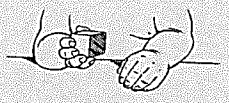
E101060200

GROSS MOTOR *(continued)*

		YES	SOMETIMES	NOT YET	
5.	If you hold both hands just to balance your baby, does he support his own weight while standing? 	○	○	○	___
6.	Does your baby get into a crawling position by getting up on her hands and knees? 	○	○	○	___

GROSS MOTOR TOTAL ___

FINE MOTOR

		YES	SOMETIMES	NOT YET	
1.	Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	○	○	○	___
2.	Does your baby reach for or grasp a toy using both hands at once?	○	○	○	___
3.	Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? *(If he already picks up a small object the size of a pea, mark "yes" for this item.)* 	○	○	○	___
4.	Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it? 	○	○	○	___
5.	Does your baby *try* to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? *(If he already picks up the crumb or Cheerio, mark "yes" for this item.)* 	○	○	○	___
6.	Does your baby pick up a small toy with only one hand? 	○	○	○	___

FINE MOTOR TOTAL ___

PROBLEM SOLVING

		YES	SOMETIMES	NOT YET	
1.	When a toy is in front of your baby, does she reach for it with both hands?	○	○	○	___
2.	When your baby is on his back, does he turn his head to look for a toy when he drops it? *(If he already picks it up, mark "yes" for this item.)*	○	○	○	___
3.	When your baby is on her back, does she try to get a toy she has dropped if she can see it?	○	○	○	___

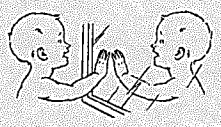
___

PROBLEM SOLVING *(continued)*

		YES	SOMETIMES	NOT YET	
4.	Does your baby pick up a toy and put it in his mouth? 	○	○	○	___
5.	Does your baby pass a toy back and forth from one hand to the other? 	○	○	○	___
6.	Does your baby play by banging a toy up and down on the floor or table? 	○	○	○	___

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

		YES	SOMETIMES	NOT YET	
1.	When in front of a large mirror, does your baby smile or coo at herself? 	○	○	○	___
2.	Does your baby act differently toward strangers than he does with you and other familiar people? *(Reactions to strangers may include staring, frowning, withdrawing, or crying.)*	○	○	○	___
3.	While lying on her back, does your baby play by grabbing her foot? 	○	○	○	___
4.	When in front of a large mirror, does your baby reach out to pat the mirror? 	○	○	○	___
5.	While your baby is on his back, does he put his foot in his mouth? 	○	○	○	___
6.	Does your baby try to get a toy that is out of reach? *(She may roll, pivot on her tummy, or crawl to get it.)*	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain: ○ YES ○ NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: ○ YES ○ NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: ○ YES ○ NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ○ YES ○ NO

5. Do you have concerns about your baby's vision? If yes, explain: ○ YES ○ NO

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

7. Do you have any concerns about your baby's behavior? If yes, explain: ○ YES ○ NO

8. Does anything about your baby worry you? If yes, explain: ○ YES ○ NO

ASQ-3 — 6 Month ASQ-3 Information Summary

5 months 0 days through 6 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby'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	29.65		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Gross Motor	22.25		●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯	◯
Fine Motor	25.14		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Problem Solving	27.72		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯
Personal-Social	25.34		●	●	●	●	●	●	◯	◯	◯	◯	◯	◯	◯

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

1. Uses both hands and both legs equally well? Yes **NO**
   Comments:
2. Feet are flat on the surface most of the time? Yes **NO**
   Comments:
3. Concerns about not making sounds? **YES** No
   Comments:
4. Family history of hearing impairment? **YES** No
   Comments:
5. Concerns about vision? **YES** No
   Comments:
6. Any medical problems? **YES** No
   Comments:
7. Concerns about behavior? **YES** No
   Comments:
8. 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 baby's total score is in the ▭ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▭ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby'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						

P101060700

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™

6 Month Questionnaire

(For infants ages 3 through 8 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**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim**

6 Month ASQ:SE Questionnaire

(For infants ages 3 through 8 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: _____

_____

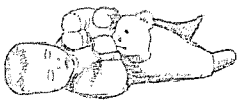
Administering program or provider: _____

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. When upset, can your baby calm down within a half hour?	❑ z	❑ v	❑ x	○
2. Does your baby smile at you and other family members? 	❑ z	❑ v	❑ x	○
3. Does your baby like to be picked up and held?	❑ z	❑ v	❑ x	○
4. Does your baby stiffen and arch her back when picked up?	❑ x	❑ v	❑ z	○
5. When talking to your baby, does he look at you and seem to be listening?	❑ z	❑ v	❑ x	○
6. Does your baby let you know when she is hungry or sick?	❑ z	❑ v	❑ x	○
7. When awake, does your baby seem to enjoy watching or listening to people?	❑ z	❑ v	❑ x	○
8. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)? 	❑ z	❑ v	❑ x	○
9. Does your baby cry for long periods of time?	❑ x	❑ v	❑ z	○
10. Is your baby's body relaxed?	❑ z	❑ v	❑ x	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
11. Does your baby have trouble sucking from a bottle or breast?	☐ x	☐ v	☐ z	○
12. Does it take longer than 30 minutes to feed your baby?	☐ x	☐ v	☐ z	○
13. Do you and your baby enjoy mealtimes together (including breast and bottle feeding)?	☐ z	☐ v	☐ x	○
14. Does your baby have any eating problems, such as gagging, vomiting, or _____ ? (You may write in another problem.)	☐ x	☐ v	☐ z	○
15. During the day, does your baby stay awake for an hour or longer at one time?	☐ z	☐ v	☐ x	○
16. Does your baby have trouble falling asleep at naptime or at night?	☐ x	☐ v	☐ z	○
17. Does your baby sleep at least 10 hours in a 24-hour period? 	☐ z	☐ v	☐ x	○
18. Does your baby get constipated or have diarrhea?	☐ x	☐ v	☐ z	○

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Has anyone expressed concerns about your baby's behavior? If you checked "sometimes" or "most of the time," please explain:	☐ x	☐ v	☐ z	○

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

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

22. What things do you enjoy most about your baby?

TOTAL POINTS ON PAGE ___

6 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	= _____
	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
6 months	45	

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?)

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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
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61501
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61544
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Gallatin
62934

Greene
62016
62027
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62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

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

Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
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61238
61274
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61443
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61490

Iroquois
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Jackson
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62950

Jasper
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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
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61414
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61489
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Lake
60040

LaSalle
60470
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61301
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Lawrence
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Lee
60553
61006
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Livingston
60420
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Logan
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Macon
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Macoupin
62009
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62649
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62686
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Madison
62002
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Marion
None

Marshall
61369
61377
61424
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Mason
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62644
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Massac
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McDonough
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McHenry
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McLean
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Menard
62642
62673
62688

Mercer
61231
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61486

Monroe
None

Montgomery
62015
62019
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Morgan
62601
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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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62343
62345
62352
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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
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62289

Saline
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Sangamon
62625
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62703

Schuyler
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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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Williamson
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Winnebago
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61101
61102
61103
61104

Woodford
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IOCI 19-599