

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: _____ Date: _____

Name of Child: _____

		Please mark under the heading that best fits your child					
		NEVER	SOME-TIMES	OFTEN			
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
(scoring totals)							

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
 PSC17 Internalizing score is sum of column I
 PSC17 Attention score is sum of column A
 PSC17 Externalizing score is sum of column E
 PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:
 PSC-17 - I \geq 5
 PSC-17 - A \geq 7
 PSC-17 - E \geq 7
 Total Score \geq 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.



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 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 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 62835 62844 62887 Whiteside 61037 61243 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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Bond 62273	Clinton 62219	Fayette 62458 62880 62885	Hardin 62919 62982 Henderson 61418 61425 61454 61460 61469 61471 61480	Kendall None Knox 61401 61410 61414 61436 61439 61458 61467 61474 61485 61489 61572	Kendall None Knox 61401 61410 61414 61436 61439 61458 61467 61474 61485 61489 61572	Macoupin 62009 62033 62069 62085 62088 62093 62626 62630 62640 62649 62672 62674 62685 62686 62690	Menard 62642 62673 62688 Mercer 61231 61260 61263 61276 61465 61466 61476 61486	Monroe None Montgomery 62015 62019 62032 62049 62051 62056 62075 62077 62089 62091 62094 62538	Pope None Pulaski 62956 62963 62964 62976 62992 Putnam 61336 61340 61363	Union 62905 62906 62920 62926 Vermilion 60932 60942 60960 60963 61810 61831 61832 61833 61844 61848 61857 61865 61870 61876 61883
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PEDIATRIC TB RISK ASSESSMENT FORM

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