

## Adult Lead Poisoning Medical Provider Questionnaire

### (Patient Confidential Information)

Oregon Lead Poisoning Prevention Program  
800 NE Oregon St., Ste. 640, Portland, OR 97232  
Phone: 971-673-0440 Fax: 971-673-0457

Case ID #:	BLL Test Date (MM/DD/YYYY):	EBLL:
Investigator Name:	Interview Date (MM/DD/YYYY):	Venous Sample: <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Name (Last)	(First) (MI)	Patient Date of Birth (MM/DD/YYYY)

#### A. Medical Provider Information:

Provider Name (Last) (First) (MI)	Provider Credential <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> ND <input type="checkbox"/> RN/NP <input type="checkbox"/> PA Specialty <input type="checkbox"/> Occ. Med <input type="checkbox"/> Fam. Prac. <input type="checkbox"/> Int. Med. <input type="checkbox"/> Other (specify): _____
Provider Address (Street) (City) (County) (State) (Zip)	
Provider Phone	Is the physician the company medical supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No" describe the physician's relationship to the tested individual: _____

#### B. Medical Information:

1. Who ordered the blood test? <input type="checkbox"/> Physician <input type="checkbox"/> Employer <input type="checkbox"/> Don't know	
2. Main reason for ordering the blood test?	
a. Patient request	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Evaluate symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Pre-employment or placement screening	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Routine medical monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Follow-up, for EBLL $\geq$ 25 $\mu$ g/dL blood	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Other reason (specify)	
3. Is the exposure primarily due to occupational source? <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes (describe)	
4. Blood lead test information:	
a. Was a physician exam associated with this test?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
b. If No or Don't know: Is or will an exam be scheduled?	<input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes
c. Any abnormalities on physical exam or labs? <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes (describe)	

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**C. Patient Signs and Symptoms:**

Patient Has <u>No</u> Symptoms <input type="radio"/>		
1. Gastro-intestinal:	<input type="radio"/> Nausea/Vomiting	<input type="radio"/> Weight loss
	<input type="radio"/> Anorexia	<input type="radio"/> Constipation
	<input type="radio"/> Abdominal cramping/ Stomach pain	<input type="radio"/> Other (describe):
2. Neurological:	<input type="radio"/> Numbness	<input type="radio"/> Clumsiness
	<input type="radio"/> Fatigue	<input type="radio"/> Irritability
	<input type="radio"/> Tingling hands	<input type="radio"/> Burning feet
	<input type="radio"/> Memory loss	<input type="radio"/> Headache
	<input type="radio"/> Weakness	<input type="radio"/> Ears ringing/buzzing
	<input type="radio"/> Muscle pain/cramps	<input type="radio"/> CNS (describe):
3. Miscellaneous:	<input type="radio"/> Insomnia	<input type="radio"/> Sore/bleeding gums
	<input type="radio"/> Respiratory difficulty	<input type="radio"/> Decreased sex drive/ Impotency
	<input type="radio"/> Infertility	<input type="radio"/> Other (describe):

**D. Patient Diagnosis:**

1. Did you make a lead related diagnosis? <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes (describe):	
2. Has the patient been notified of the blood test results?	<input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes
3. Has the employer been notified?	<input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes
4. If BLL $\geq$ 50 $\mu$ g/dL blood:	
a. Did you make recommendation to remove patient from lead exposure?	<input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes
b. To the employer?	<input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes
c. To the individual?	<input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes
5. Was the patient chelated? <input type="radio"/> No <input type="radio"/> Don't know <input type="radio"/> Yes (describe):	

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#### **D. Personal and Household:**

1. Are there children in the household? No Don't know Yes (describe age(s), relationship(s), how long in the home, and if and when they've had a BLL - give BLL result):

2. Is anyone in the household pregnant or nursing? No Don't know Yes (describe age(s), relationship(s), how long in the home, and if and when they've had a BLL - give BLL result):

3. Is anyone else in the household exposed to lead? No Don't know Yes (describe) age(s), relationship(s), how long in the home, and if and when they've had a BLL - give BLL result):

**E. Read Statement to Medical Provider:** "We will be contacting the patient to discuss their exposure to lead. Do you have any concerns that you would like to discuss?" List concerns below:

#### **F. Referral, Recommendations and Comments:**