



Eric J. Holcomb
Governor
Kristina Box, MD, FACOG
State Health Commissioner

Indiana State Department of Health
Lead and Healthy Homes Division
100 N. Senate Avenue, N855
Indianapolis, IN 46204
317-233-1630 Fax

Risk Assessment/Home Visit Refusal Form

Child's Name: _____ Date: ____/____/____ County: _____
Child's Primary Address: _____

Indiana Administrative Code 410 IAC 29-1-22 and Indiana Code IC 16-41-39.4-1 state that a child with an elevated blood lead level at or above 10 µg/dL is required to have case management services.

These services are provided to families at no cost and can help child avoid the long term, permanent consequences of lead exposure. The purpose of this document is to record any parent or guardian's refusal to allow for a risk assessment environmental investigation, educational home visit, and/or recommended monitoring of a child's lead level through blood draws and follow up laboratory testing.

By signing and returning this form to the designated case coordinator for your region, the local health department is verifying refusal of the following services (check those that apply):

- ☐ **Blood draws and laboratory testing**
- ☐ **Educational case management home visit**
- ☐ **Environmental risk assessment investigation**

Prior to refusal, all parents and guardians should be made aware of the importance of these services and the dangers associated with elevated blood lead levels in children. If a parent and/or guardian chooses to accept any of these services now or in the future, the local health department should make every effort to provide these services to the family.

Every effort should be made to ensure children receive these services. If a parent is unable or unwilling to sign the bottom of this form, please identify what steps have been taken by the local health department to secure their participation in services. Include detailed documentation such as the date attempted and type of attempt (i.e. home visit, phone call, etc).

Parent/Legal Guardian (Please Print) Parent/Legal Guardian signature (if accessible) ____/____/____
Date

Completed By (Local Health Dept. Staff Name) ____/____/____
Date

Upon completion please return to the ISDH Case Coordinator for your region:

Northern District:
Lyland Murphy Ward
Ph: (317)-233-1356
Fax: (317)-233-1630
lmurphyward@isdh.in.gov

South/Central District:
Teresa Kirby
Ph: (317)-233-8606
Fax: (317)-233-1630
tkirby@isdh.in.gov