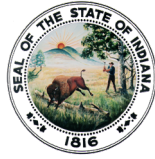




**Indiana  
Department  
of  
Health**



Eric J. Holcomb  
Governor

Kristina M. Box, MD, FACOG  
State Health Commissioner

## 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)      \_\_\_/\_\_\_/\_\_\_

Oct./2021

To **promote**, **protect**, and **improve** the health and safety of all Hoosiers.