Baltimore City Health Department

Healthy Homes
3- Month Follow Up

**Family ID:** _______________

**Case Name:** ______________ **EBL/PPI:** ________ **Child's Lead level:** ______

**Date of blood test:** ________ **Due date of next test:** _____ **Test overdue:** ___

**Child with asthma:** ____ **Names of children with asthma:** ____________

**Fill out the following table if there were any children with asthma at the INITIAL visit.**

| **Asthma Symptoms** | Name: ______________________<br>DOB: ________ | Name: __________________<br>DOB: ______ |
|---|---|---|
| Ask — During the past 3 months, how many times did this child have to stay in the hospital overnight because of asthma? | | |
| Ask — During the past 3 months, how many times did this child go to the ER because of asthma? | | |

**Address (initial visit):** ___________________ **Address (90-Day Revisit):** _______________

**Respondent:** ______________________________ **Date of Follow-up:** ________________________

**INITIAL VISIT INFORMATION**

**Visit Info**

Date of initial visit: ________ Rental/Owner occupied: ________

PHI: ______________________ SAN: _________________________

Follow-up completed by: ______________________

**Environmental Info**

Environmental case discharged: _____ Date of discharge: ________

Abatement work on property since initial visit: ________

Property abated after initial visit: _____ Date abated: ________

Results of initial dust test: ________ Re-dust needed: _____

Comments: ____________________________________________________________

**Other**

Pest problems reported: _____ Type of pest problem: ______________

**Safety hazards found at initial visit:**

- ☐ Unsafe banisters
- ☐ Unsafe stairs
- ☐ No stair gate
- ☐ Unsafe window: _______________________
- ☐ Choking hazards w/in reach of toddler: _______________
- ☐ No electric outlet cover
- ☐ Window blind cord accessible
- ☐ Firearms/knives stored unsafely
- ☐ Other: ____________________

**Areas of Concern Identified at Initial Visit**

| Medical | Environmental |
| --- | --- |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

**Special Circumstances from Initial Visit:**

**Language assistance required:** _________

## General

1. **Look at the list of "areas of concern" identified at the initial visit. Begin your visit by probing about those items. Write down any comments below:**

| |
|---|
| |

**Ask the following question for EBL cases only.**

Ask

2. When was your child's last blood test? Date: ____________________

- ☐ No test completed since initial → **Advise on need for follow-up test if test is overdue.**
- ☐ N/A- no child with EBL

Comments: ________________________________________________________________

## Awareness/Knowledge

**Please have the respondent give their best answer to the following questions. Ask the client and record the answer. Then explain the correct information.**

Ask

3. Overall, how satisfied are you with your home?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat unsatisfied
- ☐ Very unsatisfied
- ☐ Don't know
- ☐ Refused

Comments: ___________________________________________

Ask

4. Smoking inside the home can trigger an asthma flare-up.

- ☐ True
- ☐ False
- ☐ Don't know
- ☐ Refused

Ask

5. Which of the following are sources of Carbon Monoxide **in the home?** There can be more than one answer.

- ☐ Space heater
- ☐ Stove
- ☐ Steam from the shower
- ☐ Cigarette smoke
- ☐ Don't know
- ☐ Refused

Ask

6. How often should you test your smoke alarm battery?

- ☐ 1 time a year
- ☐ 1 time a month
- ☐ 1 time a week
- ☐ Once every 2 years
- ☐ Don't know
- ☐ Refused

Ask

7. What is the best way to store poisons in the home, according to safety experts?

- ☐ In a place that is high up
- ☐ In a place with doors that close
- ☐ In a place with a lock or a latch
- ☐ In a place that children don't know about.
- ☐ Don't know
- ☐ Refused

Ask

8. Which of the following are good ways to keep pests out of your home? **There may be more than one correct answer.**

- ☐ Use roach sprays (like RAID)
- ☐ Use roach bait stations/roach motels
- ☐ Keep your house free of trash and crumbs
- ☐ Use boric acid
- ☐ Don't know
- ☐ Refused

**General**

Ask

**9. Look at the following list and please circle any of the following concerns you CURRENTLY have with your home and/or family.**

| | | |
|---|---|---|
| **Asthma** | **Smoking in the home** | **Rats** |
| **Leaks** | **Mold** | **Lead** |
| **Being evicted/ Becoming homeless** | **Mice** | **Roaches** |
| **Keeping up with the cleaning** | **Electricity/gas being turned off** | **Noise** |
| **Odors** | **Keeping warm in the winter** | **Safety** |
| **Appliances that don't work** | **Keeping cool in the summer** | **Holes in the floor** |
| **Holes in walls/ ceilings** | **Broken doors** | **Broken windows** |

**Other: __________________**

**Go the KITCHEN and do the following assessment.**

Observe

10. Can you identify any hazards on the ceiling?
- ❑ Yes →
- ❑ No
- ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing/broken ceiling tiles or parts
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Chipping/peeling paint
- ❑ Other: ________________________________

Observe

11. Can you identify any hazards on the floor?
- ❑ Yes →
- ❑ No
- ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing parts
- ❑ Floor covering badly worn/soiled
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Other: ________________________________

Observe

12. Can you identify any hazards on the walls?
- ❑ Yes →
- ❑ No
- ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing parts
- ❑ Chipping/peeling paint
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Other: ________________________________

**Go to the CHILD's room and do the following assessment.**

Observe

13. Can you identify any hazards on the ceiling?
- ❑ Yes →
- ❑ No
- ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing/broken ceiling tiles or parts
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Chipping/peeling paint
- ❑ Other: ________________________________

Observe

14. Can you identify any hazards on the floor?
    - ❑ Yes →
    - ❑ No
    - ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing parts
- ❑ Floor covering badly worn/soiled
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Other: ________________________________

Observe

15. Can you identify any hazards on the walls?
    - ❑ Yes →
    - ❑ No
    - ❑ Cannot determine

If YES, check the structural defect(s) below:
- ❑ Large cracks/holes
- ❑ Severe bulging/buckling
- ❑ Small cracks/holes
- ❑ Missing parts
- ❑ Chipping/peeling paint
- ❑ Water damage
- ❑ Mold (visible/odor)
- ❑ Other: ________________________________

Observe

**16. List any other rooms in the unit that have <u>ceilings</u> with hazards.**

Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________

**17. List any other rooms in the unit that have <u>floors</u> with hazards.**

Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________

**18. List any other rooms in the unit that have <u>walls</u> with hazards.**

Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________
Room: _________________________ Describe condition: ___________________________________

Observe

19. ❑ No electricity
    - ❑ No heat
    - ❑ Has heat and electricity
    - ❑ Other heat-related issue: __________________

Observe

20. Reason for lack of electricity or heat: ________________________________

## Cleaning

Observe

21. Clutter: Rank on Hoarding Scale (1-10): ___________

22. Evidence of housecleaning?

- ☐ Appears clean
- ☐ Some evidence of housecleaning
- ☐ No evidence of housecleaning

23. Is the unit free from heavy accumulation or garbage or debris inside?

- ☐ Yes
- ☐ No →

Type of debris:
- ☐ Piles of trash and garbage
- ☐ Discarded furniture
- ☐ Other: _______________

## Asthma

Ask

24. Has anyone in this household been diagnosed with asthma in the last 3 months?

- ☐ Yes (**If YES, and if child is < 12, offer a referral to the BCHD asthma program**).
- ☐ No
- ☐ Don't know

25. See asthma table on front page

## Carbon Monoxide

Observe

26. Is there a lot of food encrusted on the range in the kitchen?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

Comments: ________________________________________

Observe & Ask

27. Does the family use the oven for heat?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

Comments: ________________________________________

## Pest Management

Ask

**IF client reported pest problem at INITIAL visit, ask:**

28. In the last 3 months, has the problem:

- ☐ Stayed the same
- ☐ Improved
- ☐ Gotten worse

Comments: ________________________________________

## Fire Safety

Observe

29. Are there working smoke detectors on all floors?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

Comments: ________________________________________

Observe

30. Is there an acceptable fire exit from this unit that is not blocked?

- ☐ Yes →
- ☐ No
- ☐ Cannot determine

- ❑ Open-able window (for ground or 1st floor units)
- ❑ Back door with opening to porch or stairs leading to ground
- ❑ Fire escape, fire ladder, fire stairs

Observe

31. Are there electrical hazards in the house?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

Ask

32. Does your family have a fire safety plan?

- ☐ Yes
- ☐ No

Ask

33. If YES, what is your family's meeting place in case of a fire?

______________________________________________

## Household Injury

Ask

34. Have there been any accidents or injuries in the house in the past 3 months? (trips, falls, scalds/burns etc.)

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

If YES, describe the injury and the age of the person who was injured.

______________________________________________

If YES, did any of these accidents or injuries require a trip to the Emergency Room?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Observe

35. Check off any of the following safety hazards:

- ☐ Unsafe banister
- ☐ Unsafe stairs
- ☐ No stair gate
- ☐ Unsafe window
- ☐ No electric outlet cover
- ☐ Window blind cords accessible
- ☐ Choking hazards w/in reach of toddler
- ☐ Firearms/knives stored unsafely

Comments: __________________________________

Ask

36. Are there any infants living in this house?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Ask

37. If YES, do they each have their own crib?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Refused

Observe

38. Is the crib located in a safe place?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

Comments: ___________________________________

**Smoking**

Ask

39. How many people regularly smoke in the home?

________________________________________

Observe

40. Is there evidence of smoking?

- ☐ Yes
- ☐ No
- ☐ Cannot determine

41. If YES, please indicate the type of evidence:

- ☐ Cigarette butts
- ☐ Smoke in the air
- ☐ Discarded cigarette
- ☐ Ashtrays with ash
- ☐ Person smoking
- ☐ Cigarette pack
- ☐ Ashtrays
- ☐ Lit cigarette
- ☐ Other: _________________

| **REFERRALS:**<br>*Put a check in INITIAL if referral was made. Indicate the "status" in FOLLOW-UP.* | **Initial** | **Follow-Up (Did they actually participate? Are they still participating?)** |
|---|---|---|
| Baltimore Infants and Toddlers | ☐ | |
| BCHD Asthma Program | ☐ | |
| Breathmobile | ☐ | |
| LAAP | ☐ | |
| Coalition | ☐ | |
| 311/Housing | ☐ | |
| WIC | ☐ | |
| Food Stamps | ☐ | |
| Department of Social Services | ☐ | |
| Home Energy Assistance | ☐ | |
| Quit Smoking Program | ☐ | |
| Legal Aid | ☐ | |
| Mental Health Services | ☐ | |
| General housing assistance (specify) | ☐ | |
| Johns Hopkins Safety Center | ☐ | |
| National Student Partnerships | ☐ | |
| Bon Secours | ☐ | |
| Family Tree | ☐ | |
| Other: ______________________ | ☐ | |

Ask

Here is a list of some agencies we may have referred you to.
Were you referred to any of the following agencies by the Health Department?

☐ Baltimore Infants and Toddlers

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ The Breathmobile

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ Baltimore Health Dept Asthma Program

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ The Coalition to End Childhood Lead Poisoning

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ Lead Abatement Action Project (LAAP)

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ 311 / Baltimore City Department of Housing

Comment:________________________________________________________________

________________________________________________________________________

________________________________________________________________________

| ITEMS DISRIBUTED: Initial Visit | Initial | Comments |
|---|---|---|
| Cleaning kit | ☐ | |
| Roach motels | ☐ | |
| Mouse traps | ☐ | |
| Giant gift card | ☐ | |
| Crib | ☐ | |
| Other: | ☐ | |

**Please make note below of any interventions that occurred during the follow-up visit.**

**Referrals made:** ___________________________________________________________
___________________________________________________________

**Other relevant items:** ____________________________________________________
____________________________________________________