●670J THE APPLICABILITY OF THE DENVER PRESCREENING DEVELOPMENTAL QUESTIONNAIRE (DPDQ) IN A LOWER SOCIOECONOMIC POPULATION. Cristina Chua-Lim, Michael S. Rosenbaum, Joan Wilhite, Vipul N. Mankad (Spon. by R.M. Suskind). University of South Alabama College of Medicine, Mobile, Alabama.

Since the validity of the DPDQ has been examined only in predominantly White middle class populations in Denver, CO, a prospective study was conducted to assess the validity of the questionnaire in a predominantly indigent Black population. The effect of an educational package in increasing the accuracy of parental response to DPDQ as also assessed.

127 infants were enrolled in a longitudinal follow-up program from age 2 wks to 1 yr. Parents in a randomly selected experimental group observed an audiovisual presentation describing progressive developmental behavior and were asked to record their child's subsequent development.

78 of the 127 infants were followed for 3 mos, while 53 and 33 have been followed for 6 and 9 mos, respectively. The mean agreement scores between parental responses to the DPDQ and the observed development via DDST were 93.6%, 93.2% and 91% at 3, 6, and 9 mos, respectively. There were no significant differences in the item agreement scores of the experimental group vs the control group thereby demonstrating failure of the educational program in increasing the accuracy of parents. The overreferral rate was quite low (12.8%).

The results attest to the validity, generality and feasibility of DPDQ in a lower socioeconomic population and raise some questions about parent education through audiovisual and written materials.

671 EFFECT OF PROBLEM ORIENTED RECORD COMPONENTS ON HOSPITAL CARE. Carmi Z. Margolis, Wilhelmina Cohen, Nurit Barak. Faculty of Health Sciences, Ben Gurion University of the Negev, Primary Care Unit, Beersheba, Israel.

We implemented a standardized data base (SDB) and problem list (PL) in two 50-bed general pediatric wards X and Y, and measured number of problems identified and amount of data collected in 100 randomly sampled records from each ward before (period 1), immediately after (period 2), and one year after implementation (period 3).

Mean subjective data score at periods 1,2 and 3 was 14.96+S.D. 5.57, 28.18±S.D.9.76 ($p=<0.005$) and 28.7±S.D.9.53 respectively, (maximum possible=50). Mean objective data score at periods 1,2 and 3 was 10.97±S.D.4.96, 17.64±S.D.1.78 ($p=<0.005$) and 17.48±S.D. 1.7, respectively (maximum possible=21). There was no significant difference between wards X and Y, mean number of problems identified on admission to ward X at periods 1,2 and 3 was 2.22 (range 1-6; mode 1; median 2), 2.08 (range 1-5; mode 1; median 2), 2.17 (range 1-6; mode 1; median 2), 2.18 (range 1-6; mode 1; median 2), 2.17 (range 1-6; mode 1; median 2). Percentage of records with 3 problems on discharge from ward X at periods 1,2 and 3 was 50%, 40% and 52%, respectively, and for ward Y, 25%, 39% ($p=<0.025$) and 42%.

An SDB can increase significantly amount of data collected on admission to a general pediatric ward, and maintain the increase for at least one year. The PL may increase number of problems identified if the number is relatively small before PL implementation.

672 $CaNa_2EDTA$ PROVOCATIVE TESTS (EPT's) IN CHILDREN WITH MILD-MODERATE INCREASED LEAD (Pb) ABSORPTION. Morri E. Markowitz, John F. Rosen, Paul Saenger, Albert Einstein Coll. Med., Dept. of Ped., Montefiore Hosp. Med. Ctr., N.Y.

Screening programs for Pb poisoning emphasize measurements of blood Pb and erythrocyte protoporphyrin (EP). A far more sensitive index of the size of chelatable and potentially toxic Pb stores, the EPT, has yet to be evaluated in children with mild-moderate increased lead absorption. EPT's were performed in 20 such children: 4 CDC Class II (Pb 30-49µg/dl, EP 50-109µg/dl) and 16 in Class III, who were further subdivided: IIIa (Pb 30-49µg/dl, EP > 110µg/dl) and IIIb (Pb 50-69µg/dl, EP>50µg/dl). $CaNa_2EDTA$ (500 mg/m^2/dose) was given q 12 H x 2, and the 24-hour urinary Pb (^{U}Pb) excretion was measured. A positive EPT was defined as urinary excretion of Pb ≥ 500µg/24H.

Results:	^{U}Pbµg/24H	^{U}Pb≥500µg/n	r(Pb/EP)	r(Pb/^{U}Pb)	r(EP/^{U}Pb)
Class II	443±101*	2/4	.061	.481	-.478
Class IIIa	818±194*	6/8	-.100	.319	.297
Class IIIb	813±274*	6/8	.754**	.488	.623

n=number of subjects; r=correl. coeff., *=mean±S.E.; **=$p<.05$

Conclusions: 1) Measurements of blood Pb and/or EP are imprecise indicators of chelatable Pb, as determined by the EPT, in children with mild-moderate increased Pb absorption; 2) 70% of all children in this study required 5 days of treatment for increased Pb absorption; 3) Based on conventional screening tests, these children may have gone untreated; 4) We suggest that all children with blood Pb>30 and EP>50 should have careful assessment of the size of chelatable Pb stores by a precise method, namely, the $CaNa_2EDTA$ provocative test.

673 PROBLEM-ORIENTED PHYSICIAN NEONATAL INTENSIVE CARE PROGRESS NOTES. G. Martin, W. Ireland, G. Furman, J. Streng, H. Speil, R. Bertolin, R. Neuenschwander and N. Johnson. (Spon. by P. Wu). Departments of Neonatology and Pediatrics, the Magan Medical Clinic, Covina, California.

Care of the newborn in an intensive care setting necessitates continuous monitoring and evaluation. Changing clinical status, laboratory data, fluid balance, nutritional information, and respiratory therapy are important parts of this care. Graphic representation of this data is essential for continual care and retrospective analysis. Each discipline involved in NICU care (nurse, respiratory therapist, laboratory assistant) have devised "forms" to assist them in caring for the sick neonate. The physician needs a simple form to record clinical notes and other information to prevent communication lapses and forgotten information.

We have designed a physician progress page which encompasses three separate problem-oriented records. The initial morning visit records present problems, current laboratory data, medications, pertinant physical findings, and the plan for the next few hours. A midday note on the back side of the page offers continual problem-oriented information with a therapy plan. The final note underneath the midday exam restates the problems, adds additional data, and organizes therapy. Interim visits, if necessary, are noted on regular progress notes. This method of physician problem-oriented progress notes eliminates forgotten or inaccurate information, organizes neonatal planning, and allows for a more complete summary at discharge.

674 THE ROLE OF THE PRIVATE PEDIATRICIAN IN FOLLOW-UP OF NEONATAL INTENSIVE CARE GRADUATES. G. Martin, W. Ireland, G. Furman, J. Streng, H. Speil, R. Bertolin, R. Neuenschwander, and N. Johnson. (Spon. by P. Wu). Department of Pediatrics, Magan Medical Clinic, Covina, California.

Although mortality and morbidity statistics are continually improving, benefits of NICU care for the infant weighing less than 1,500 grams will be measured in long term follow-up. Compliance rates in hospital-based follow-up programs are poor due to geographic limits, financial considerations, ethnic adjustments, and poor communication. Since most births occur in the community hospital settings, and parents will gravitate to private pediatricians, it seems natural that the pediatrician be involved in the care of NICU graduates in a well-defined program. The pediatrician oftentimes has intimate knowledge of the family, its goals and attitudes. Knowledge about referral centers, financial aid, and counseling within the community point to a more direct role for the private pediatrician. An organized approach includes a program for the first and subsequent well child visits and a protocol for recording growth data, nutritional information, laboratory data, Denver Developmental Testing, psychological evaluations, auditory and visual evoked potentials, photographs, and subspecialty referrals. If the neonatologist at the tertiary center organizes this "private pediatric group", a program can evolve which will service more physicians and patients. The pediatrician will remain interested in the total spectrum of NICU care, and will insure continuity of total care.

675 NON-CATEGORICAL IDENTIFICATION OF INFANTS WHO ARE AT RISK FOR FUTURE HANDICAPPING CONDITIONS. Eva T. Molnar, Antoine K. Fomufod, Jeffrey D. Blake, and Fariborz Rahbar (Spon. by Melvin E. Jenkins) from the Dept. of Pediatrics and Child Health, Howard Univ. Col. of Med., Washington, D.C.

In 1975, Public Law 94-142 directed the states to develop a plan for identifying all handicapped children in the states and to determine who is or not being served. Compliance with this mandate became the prerequisite for receiving federal grants for services to any handicapped children. The five component elements of all identification programs were to be: screening, case finding, diagnosis, educational assessment, and program evaluation. The need for federal funds for these services cannot be overemphasized in view of the staggering financial drain on the families and states.

This article addresses the screening component and proposes an identification system for neonates at risk for future handicapping conditions. In tabular form, the system consists of: Perinatal Diagnostic Category, Clinical Symptoms and Signs, Target Organ System Affected, Subsequent Morbidity, and Risk Probability. This approach has several advantages:

1. Selection of infants for participation in federally funded programs based on risk probabilities.
2. Rapid targeting of organ systems for potential morbidity and early intervention to prevent or ameliorate the same.
3. Provides a realistic base on which to discuss management and its outcome with parents.