



Charlie Crist
Governor

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State Surgeon General

Complete and fax to (305) 470-5533

Childhood Lead Poisoning Prevention Program

Any questions, please call (305) 470-6877

Patient Name: _____ Sex: ____ Date of Birth: _____

- | | | |
|---|--------------------------------------|---------------------------------------|
| Last | First | |
| Race: (please check) | Language: (please check) | Ethnicity: (please check) |
| <input type="checkbox"/> White | <input type="checkbox"/> Spanish | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> English | <input type="checkbox"/> Non-Hispanic |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Creole | <input type="checkbox"/> Haitian |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Am. Indian/Alaska Native | | |
| <input type="checkbox"/> Other (specify _____) | | |

Country of Birth: _____ Entry Date to US: _____

Type of insurance: (please check) Public (i.e. Medicaid) Private Other: _____

Parent/Guardian Name: _____
Last First

Relationship to child: _____ Phone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Blood Lead Result: _____ µg/dL Sample Type: (check one) Screened Site: (check one)

- | | | |
|-------------------------------|------------------------------------|--|
| Sample Date: ____/____/____ | <input type="checkbox"/> Capillary | <input type="checkbox"/> Clinic |
| Analyzed Date: ____/____/____ | <input type="checkbox"/> Venous | <input type="checkbox"/> CLPPP Clinic |
| | | <input type="checkbox"/> Private Physician |
| | | <input type="checkbox"/> Other Fixed Site |

Lab Report Date: ____/____/____ Laboratory sent to: (check one)

- | | |
|---|---|
| Hemoglobin Test Result: _____ Date: _____ | <input type="checkbox"/> Lab Corp |
| | <input type="checkbox"/> Quest/ Nichols Lab |
| | <input type="checkbox"/> Jackson Memorial Hosp. Lab |
| | <input type="checkbox"/> State Lab |

PLEASE ATTACH COPY OF LAB TEST RESULT

Physician Name: _____

Physician Office: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Provider Phone #: _____ Fax #: _____

Test Reason: (check one)

- Medicaid EPSDT
- Follow-up
- Routine Screen
- Confirmatory
- Symptoms



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