

Confidential Medical Record

<p>Send to: Texas Childhood Lead Poisoning Prevention Program Texas Department of State Health Services PO Box 149347, MC1964 Austin, TX 78714</p> <p>Fax Number: (512) 776-7699 Phone Number: (512) 776-6632 or 1-800-588-1248 (Toll-free)</p>	<p>From: Provider Name:</p> <p>City/State/ZIP:</p> <p>Phone Number: () Fax Number: ()</p>
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Child Information		
Last Name:	First Name:	M.I.
Date Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age in Months:	Medicaid/EPSTD #:	
Current Address:	Apartment #:	
City:	State:	Zip:
Ethnicity: <i>(check one)</i>		
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown
Child Race: <i>(check one)</i>		
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Native American or Alaskan Native	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Unknown

Blood Lead Level Information	
Blood Lead Test Level: _____ micrograms per deciliter(mcg/dL)	Test Date: ____ / ____ / ____
Type of Blood Sample: <i>(check one)</i>	
<input type="checkbox"/> Capillary	<input type="checkbox"/> Venous <input type="checkbox"/> Unknown
Testing Laboratory:	If Using LeadCare System, Place Label Here
Laboratory Phone: ()	

Attending Physician Information	
Last Name:	First Name:
Location (City):	

For TX CLPPP Use Only	
Person Receiving Report:	Date Received: ____ / ____ / ____