TEXAS Department of State Health Services

Childhood Blood Lead Level Report

Form F09-11709

Confidential Medical Record

Fax or Mail Form To:	**↓ If Using Custom Address Stamp, Stamp Here ↓**
Texas Childhood Lead Poisoning Prevention Program Texas Department of State Health Services PO Box 149347, MC1964 Austin, TX 78714 **Fax Number**: (512) 776-7699	

Child Information

Child's Last Name | **First Name** | **M.I.**

Date of Birth *(mm/dd/yyyy)* | **Social Security #** | **Medicaid #**

Gender: (*check one*) ☐ Male ☐ Female

Ethnicity: (*check one*) ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Child Race: (*check one*) ☐ White ☐ Black ☐ Asian or Pacific Islander ☐ Native American or Alaskan Native ☐ Multi-Racial ☐ Unknown

Current Address: | **Apartment #**

City | **State** | **Zip**

Blood Lead Level Information

Test Date *(mm/dd/yyyy)* | **Blood Lead Level** *(µg/dL)* | **Sample Type** (*check one*) ☐ Capillary ☐ Venous ☐ Unknown | **LeadCare II** (*check one*) ☐ Yes ☐ No

Testing Laboratory Name

Laboratory Phone

Laboratory City

↓ If Using LeadCare System, Place Label Here ↓

Healthcare Provider Information

Provider Last Name | **First Name** | **Middle Name**

Clinic Name | **Phone #** | **Fax #**

Clinic Address: | **Suite #**

City | **State** | **Zip**