



Texas Department of State Health Services

Childhood Blood Lead Level Report

Form F09-11709

Confidential Medical Record

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

Telephone: _____ City: _____ State: _____ Zip: _____

Blood Lead Level Information

Test Date (mm/dd/yyyy): _____ Blood Lead Level (µ/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: _____