

## Confidential Medical Record

<b>Fax or Mail Form To:</b> Texas Childhood Lead Poisoning Prevention Program Texas Department of State Health Services PO Box 149347, MC1964 Austin, TX 78714 <b>Fax Number:</b> (512) 776-7699	↓ If Using Custom Address Stamp, Stamp Here ↓
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<b>Child Information</b>			
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
<b>Child's Last Name</b>	<b>First Name</b>	<b>M.I.</b>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Date of Birth</b> (mm/dd/yyyy)	<b>Social Security #</b>	<b>Medicaid #</b>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Gender:</b> (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Ethnicity:</b> (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<b>Child Race:</b> (check one) <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	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
<b>Current Address:</b>			<b>Apartment #</b>
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Telephone</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>

<b>Blood Lead Level Information</b>			
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Capillary <input type="checkbox"/> Venous <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Test Date</b> (mm/dd/yyyy)	<b>Blood Lead Level</b> (µ/dL)	<b>Sample Type</b> (check one)	<b>LeadCare II</b> (check one)
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>Testing Laboratory Name</b>		↓ If Using LeadCare System, Place Label Here ↓	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Laboratory Phone</b>			
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
<b>Laboratory City</b>			
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			

<b>Healthcare Provider Information</b>			
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			
<b>Provider Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Clinic Name</b>	<b>Phone #</b>	<b>Fax #</b>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
<b>Clinic Address:</b>			<b>Suite #</b>
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>			<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<b>City</b>	<b>State</b>	<b>Zip</b>	
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	