Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Complete and fax to (305) 470-5533

Childhood Lead Poisoning Prevention Reporting Form

Any questions, please call (305) 470-6877

Patient Name: _____, _____ **Sex:** ___ **Date of Birth:** _____
Last First

Race: **(please check)**
- ☐ **White**
- ☐ **African American/Black**
- ☐ **Asian**
- ☐ **Native Hawaiian/Pacific Islander**
- ☐ **Am. Indian/Alaska Native**
- ☐ **Other (specify _____)**

Language: **(please check)**
- ☐ **Spanish**
- ☐ **English**
- ☐ **Haitian-Creole**
- ☐ **Other** _____

Ethnicity: **(please check)**
- ☐ **Hispanic**
- ☐ **Non-Hispanic**
- ☐ **Haitian**
- ☐ **Other** _____

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 Date: ____/____/____

Analyzed Date: ____/____/____

Lab Report Date: ____/____/____

Hemoglobin Test Result: _____ **Date**: _____

Sample Type: (check one)
- ☐ Capillary
- ☐ Venous

Screened Site: (check one)
- ☐ Clinic
- ☐ CLPPP Clinic
- ☐ Private Physician
- ☐ Other Fixed Site

Laboratory sent to: (check one)
- ☐ Lab Corp Tampa
- ☐ Quest Diagnostics
- ☐ _____

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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Epidemiology, Disease Control and Immunization Services
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Miami, FL 33126
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Accredited Health Department
Public Health Accreditation Board