CHILDHOOD LEAD POISONING REPORT FORM

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control and Immunization Services (EDC-IS)
1350 N.W. 14th Street, Annex Building Florida, 33125

The Florida Department of Health in Miami-Dade received a positive laboratory result that is listed in the *Table of Reportable Diseases or Conditions to Be Reported Rule 64D-3.0029, Florida Administrative Code (FAC)* on the following patient:

Patient name: ______ DOB: ______ Lab report date: ______

Please complete the sections below and return to confidential fax# (305) 470- 5533

Completing the information will supplement information provided for public health surveillance and Epidemiologic investigations as per Chapter 64D-3.030, *FAC*. HIPPA* does not change reporting obligations.

A. PATIENT DEMOGRAPHIC INFORMATION

If you have any questions, call (305) 470-5660 and ask for ______

Name of parent/guardian: ________________________________

Relationship to child: ___________________________________ Phone Number: _______________________

Patient address: ______ City & State: ______ Zip code: ______

Phone number: ______ Emergency Phone number: ______

Gender: ☐Female ☐Male Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐ American Indian/Alaskan Native ☐Asian/Pacific Islander ☐Black ☐ White ☐Other: ______

Country of Birth: ________________________________ Entry Date to US: __________________________

Type of insurance: (please check) ☐ Public (i.e. Medicaid), ☐ Private, ☐ Other: _________________________

B. CLINICAL INFORMATION

Name of primary physician: ________________________________

Physician Office: ____

Provider Address: ____
City: _________________________________State: ____________ Zip:__________
Provider Phone #: ___________________ Fax #: ___________________________

Test Reason: (check one)

- ☐ Medicaid
- ☐ Follow-up
- ☐ Routine Screen
- ☐ Confirmatory
- ☐ Symptoms

Blood Lead Result: ______________µg/dL

Sample Type: (check one)

- ☐ Capillary
- ☐ Venous

Screened Site: (check one)

- ☐ Clinic
- ☐ CLPPP Clinic
- ☐ Private Physician
- ☐ Other Fixed Site

Sample Date: ____/____/____

Analyzed Date: ____/____/____

Lab Report Date: ____/____/____

Hemoglobin Test Result: ________ Date: ________

Laboratory sent to: (check one)

- ☐ Lab Corp Tampa
- ☐ Quest Diagnostics
- ☐ _________________

PLEASE ATTACH COPY OF LAB TEST RESULT

*HIPPA Section 45 CFR 160.203(c) and 45 CFR Section 164.512 (b)

Health Department use only: *Date: ________________* *Investigator: ______________________________* *Merlin#:___________________*

Updated: 7/18