Point-Of-Care Blood Lead Testing Report

Form Pb-111

TEXAS Department of State Health Services

This is a screening instrument, samples considered capillary. If elevated, send venous sample to your reference laboratory for analysis

Fax this form to 512-776-7699 **Texas Childhood Lead Poisoning Prevention Program**	Provider Name ______________________ Phone (_______) _______ - _____________ Address ______________________ City______________________ State _______ Zip _______

Codes for Race: **I** = *American Indian or Alaskan Native* **A** = *Asian* **B** = *Black or African American*
P = *Native Hawaiian or Other Pacific Islander* **W** = *White* **O** = *Other*

Child's First Name	M.I. Last Name	Birth Date	Sex	Race	Hispanic	Medicaid#
		MM/DD/YYYY	M F	I A B P W O	Yes No	9 digits

Date of Test MM/DD/YYYY	Result mcg/dL	Address	Apt#	City	State	Zip

Child's First Name	M.I. Last Name	Birth Date	Sex	Race	Hispanic	Medicaid#
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Texas Childhood Lead Poisoning Prevention Program
PO BOX 149347, MC1964 ▪ Austin, TX 78714-9347 ▪ 1-800-588-1248 ▪ www.dshs.state.tx.us/lead

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