Indiana Childhood Lead Poisoning Prevention Program Blood Test

State Form 14465 (R9/12-04)

CONFIDENTIAL INFORMATION

Section 1: Patient Information

Name_____ DOB___/___/___ Sex ☐ F ☐ M Pregnant Woman ☐Y ☐N What Trimester? ___
Last First MI

Address _____ County_____ Telephone _(_____)_____
Street City State ZIP

*Soc Sec #_____ Ethnic: ☐ Hispanic ☐ Non-Hispanic ☐ Other ☐ Unknown

*Your Social Security number is being requested to pursue statutory responsibilities. Disclosure is voluntary.

Race: ☐ White ☐ Black ☐Asian/Pacific ☐American Indian ☐Alaskan ☐Unknown

Parent/Guardian _____ Telephone __(_____)_____
Last First MI

How did you hear about the screening opportunity: ☐ TV ☐ Newspaper ☐ Radio ☐ WIC ☐ Health Dept. ☐ Doctor/Nurse ☐ Letter

Section 2: Health Insurance

Type: Medicaid ☐ Private ☐ Patient Pay ☐Other ☐Unknown ☐ Medicaid # _____

Patient ID # (*Private*) _____ Group ID # (*Private*) _____

Primary Care Physician _____ Telephone __(_____)_____

Section 3: Sample Submitter Information

Name _____ County # _____ Provider # _____

Address (☐*Test site* ☐*Provider Change*) _____

Telephone __(_____)_____ Person Drawing Blood (*Please Print*) _____

Section 4: Blood Sample Information

Date of blood draw ____/____/____ Sample Type: ☐Capillary ☐Venous

Test Reason: ☐Routine ☐Confirmatory ☐Pb follow-up ☐Symptoms

Test Site: ☐Clinic ☐Door to Door ☐ Primary Physician ☐Other Fixed Site

Affix TUBE LABEL	Copy Tube Label #

Comments: _____

_____

Lab Received Date _____ Lab Specimen # _____

Consents:

Patient/Parent/Guardian: By signing this form, I am giving consent, as a patient/parent/guardian, for a blood sample to be taken from me or my minor child to determine if there is an elevated level of lead. Under Indiana law, the results of the blood lead test performed on a child less than (7) seven years of age must be reported to the Indiana State Department of Health (IC 16-41-39.4-3 and 410 IAC 1-2.3-48). These results are confidential and cannot be released except as provided for under IC 16-41-8-1. One of these exceptions provides for the release of such information as set forth under IC 16-41-39.4-4.

Indiana Code 16-41-39.4-4 requires the Indiana State Department of Health, the Family Social Services Administration, and the local health departments to share among themselves and with the Federal Department of Health and Human Services *(which includes the Centers of Disease Control and Prevention (CDC))* information, including the child's name, address, and demographic information concerning the concentration of lead in the blood of the child to determine the prevalence shared with state and local programs covered by the U.S. Department of Housing and Urban Development pursuant to 24 CFR Subpart A, Part 35 to ensure that children potentially affected by lead-based paint and lead hazards are adequately protected from lead poisoning.

- I have read the foregoing and understand that the above-mentioned information, including the results of the blood lead test, will be shared with and among the above mentioned agencies.
- I have read the foregoing and hereby give consent for a blood sample to be taken from me or my child for testing for blood lead.

☐Signature of patient ☐Parent ☐Guardian _____ Date ____/____/____

Screening Professional:

☐ I certify that a valid and current parental consent form, signed within the last 12 months, is on file as part of the above-named client's medical records and the consent form is housed and maintained at the same address as reflected in Section 2 as the ICLPPP Provider Site.

☐ I certify that the consent form and medical records for this client are housed and maintained at the provider address as reflected in Section 2 and a copy of said record is available upon request by the Indiana State Department of Health.

☐ I certify that if the medical record and consent form for this client is not housed at the site of the provider address found in Section 2, that said record may be found at the following location.

Street_____City_____ State_____ Zip_____

☐ I certify that any and all medical information received from private laboratories, either in-state or out-of-state, which comes to my attention will be forwarded to Indiana Child Lead Poisoning Prevention Program for medical record retention.

Signature of Screening Professional _____ Date ____/____/____

COPY DISTRIBUTION: White: State; Canary: ICLPPP Drawing Site, Initial *(provider retains at drawing site)*