Central Montana Health District
one HEALTH
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Lewistown, MT 59457
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Proudly Serving Golden Valley, Judith Basin, Musselshell, Petroleum, and Wheatland Counties

Blood Hemoglobin / Hematocrit & Lead Screen Request and Consent Form

Date: _____ Child's name: _____ DOB: _____ Age: ___ Sex: M __F__ Other___

Race: ___ White ___ Native American/Alaska Native ___ Asian ___ African American ___ Other ___

Ethnicity: ___ Hispanic/Latino ___ Not Hispanic/Latino ___ Unknown

Primary Address: _____

Years at this address: _____ Hours per week at this residence_____

Parent/Guardian: _____ Address: _____

Phone: _____ Alternate Phone: _____

Healthcare Provider: _____Address: _____Phone: _____

RISK ASSESSMENT (please mark/circle any that pertain to your family)

HOME: Rent ___ Own ___ Built before 1950 ___ Built from 1950-1978 ___ Built after 1978 ___

Remodeling? **Y N** Chipping Paint? **Y N** Vinyl mini blinds? **Y N** Repainting? **Y N**

Family employment: Auto repair, construction or demolition, battery repair or recycling, smelting, welding, radiator repair, work on firing ranges **Y N**

Family home: Imported food, medicine, cosmetics, toys, pottery, crystal or jewelry **Y N**

Family hobbies: Reloading bullets, casting sinkers, ceramics, stained glass, pottery **Y N**

CONSENT (please mark one of the following): ☐ **Lead Screen** ☐ **Hemoglobin/Hematocrit** ☐ **Both**

I_____, am the parent/legal guardian of _____and consent to the tests indicated above for the above-named child, rendered by Central Montana Health District. I understand that I will be counseled about the effects of lead, the most common sources of lead, and common practices to avoid lead poisoning. I further understand that the results of this test will be shared with my primary healthcare provider, identified above, and Central Montana Head Start. Any required follow-up due to abnormal results will be managed by Central Montana Health District, including contacting parents and healthcare providers.

_____ _____

Parent/guardian signature Date

CMHD STAFF USE ONLY

Capillary Collection Date: _____Puncture Site: RT Left Hand 1st 2nd 3rd 4th Finger

Nurse Signature: _____ Analysis Date: _____

Method: LeadCare II

Result: _____ug/dl Repeat: _____ug/dl

If Abnormal, Report Date: _____

Reagent Lot Number: _____

Expiration Date: _____

Method: HemoPoint H2

Result: _____g/dl (Hgb) _____% Hct

If Abnormal, Report Date: _____

Cuvette Lot Number : _____

Expiration Date: _____

Working together to bring Health & Wellness to Central Montana!