Santa Clara Family Health Plan™

Lead Screening Blood Level Monitoring Standing Order

Children 12 months – 24 months

A completed copy of this form should be kept in the SCFHP member's record.

Member Information

Name: _____ **Date:** _____

Date of Birth: _____ **SCFHP ID:** _____

Provider Information

Primary Care Provider: _____

Phone: _____ **Fax:** _____

Blood Level Testing Repeat any BLL 3.5 mcg/dl or > with a venous sample	**Route**	**Result**
☐ 12 month Well Child Visit	☐ Cap ☐ Venous	
☐ Other: Catch up test after 12 month BLL	☐ Cap ☐ Venous	
☐ 24 month Well Child Visit	☐ Cap ☐ Venous	
☐ Other: Catch up test after 24 month BLL	☐ Cap ☐ Venous	
☐ Other: Catch up test after 24 months up to 72 months	☐ Cap ☐ Venous	
☐ Other: Repeat test for BLL 3.5 mcg/dl or >	☐ Venous	

Provider Name (Please print) | **Provider Signature** | **Date**

Parent/Guardian Refusal of Lead Screening

As the parent or guardian to the SCFHP member listed above, I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I decline my child being blood tested in order to determine if he/she is lead poisoned, and hereby refuse blood lead testing. I am aware that a copy of this refusal will be documented in my child's medical record.

Reason for Refusal: _____

☐ Parent ☐ Guardian

Parent/Guardian Name (Please print) | **Parent/Guardian Signature** | **Relation to SCFHP Member** | **Date**