Minneapolis
City of Lakes

CONFIDENTIAL FAX

Referral for Free Lead In-home Visual Assessment for City of Minneapolis Residents

FAX TO: 612-673-3866
Attn: Andrea Aga Department of Health and Family Support, City of Minneapolis
(ph. 612-673-3207); (email: andrea.aga@ci.minneapolis.mn.us)

(Note to clinic: Please have the patient or person calling the patient read the disclosure statement on the back of this form. Have either the patient or the person contacting the patient initial the below disclosure statement to indicate that they have read the statement. When faxing this form to MDHFS please fax both sides of the form to us. Thank you!)

Referring Clinic: _____ Contact Name: _____ Phone Number: _____

Name of Parent or Guardian: _____

Information for the Child: Name: _____ D.O.B.: _____ Gender: F or M

Address: _____

Phone Number: _____

Language Spoken in the Home: _____

Blood lead level:
□ Under 5 µg/dl **Venous/Capillary test result**
□ 5-9 µg/dl **Venous/Capillary test result**
□ 10 µg/dl or over **Capillary test result** * Note a follow up venous test is **REQUIRED*** (Referral will be held by MDHFS until venous test result is received)
***10ug/dl or over **Venous test result:** Mandated case--Minneapolis Department of Regulatory Services and Minneapolis Public Health Nurse (MVNA) will work with family.

For all referrals—One of the following community-based partners will be contacting the family:

(NOTE: If the clinic or the patient has a preference as to what community-based partner contacts the patient, please check the appropriate box below.)

- ❖ ClearCorps USA □
- ❖ Southeast Asian Community Council □
- ❖ Sustainable Resources Center □

Notes: _____

(**SEE REVERSE SIDE)**

Tennessen Warning Disclosure Statement (English)

The purpose of this form is to obtain health information relevant to a blood lead level as evidenced by medical testing in order to provide a lead risk assessment and other services that may assist in lowering the blood lead level. Some of the information you are being asked to provide to Minneapolis Department of Health and Family Support ("Department") and/or the Department's Community Partners ("Partners") may be considered private or confidential under the Minnesota Government Data Practices Act, Minnesota Statutes chapter 13. You may legally refuse to sign this referral form. If you refuse to sign the referral form, the Department and and/or its Partners will not be able to quickly offer you the lead risk assessment and other services available to you. If you do not sign the referral form, the Department must wait to contact you until the test results are received from the State of Minnesota. The persons who may receive this data include individuals who are involved in the lead risk assessment and related services, including employees of the Partners, the Minneapolis Department of Regulatory Services, the Minnesota Visiting Nurses Association, the State of Minnesota Health Department and the Hennepin County Department of Health. The information may also be shared with attorneys representing any of the above individuals or entities or to others through subpoena or pursuant to Federal and State law.

I have read this statement _____(patient's initials)

I have read this statement to the patient _____ (Clinic staff person's initials)

Advertencia Tennessen, Declaración de Divulgación (Spanish)

El propósito de este formulario es obtener información de salud relacionados con un nivel de plomo en la sangre según las evidencias de las pruebas médicas, con el fin de proporcionar una evaluación del riesgo del plomo y otros servicios que pueden ayudar a reducir el nivel de plomo en sangre. Parte de la información que se le pide es para darla al Departamento de Salud y Apoyo Familiar de Minneapolis ("Departamento") y / o los Socios de la Comunidad con el Departamento ("socios") se puede considerar privada o confidencial en el marco del Gobierno de Minnesota Ley de Prácticas de datos, Minnesota Estatutos del capítulo 13. Usted puede legalmente negarse a firmar este formulario de remisión. Si usted se niega a firmar el formulario de referencia, el Departamento y / o sus socios no serán capaces de ofrecer rápidamente a la evaluación del riesgo del plomo y otros servicios disponibles para usted. Si usted no firma el formulario de envío, el Departamento tiene que esperar para comunicarse con usted hasta que sus resultados sean recibidos del Estado de Minnesota. Las personas que pueden recibir estos datos incluyen a individuos que están involucrados en la evaluación del riesgo del plomo y servicios relacionados, incluidos los empleados de las agencias en asociación con, el Departamento de los Servicios Regulatorios de la Ciudad de Minneapolis, La Asociación de las Enfermeras Visitantes de Minnesota, el Departamento de Salud del Estado de Minnesota y el Departamento de Salud del Condado de Hennepin. La información también podrá ser compartida con los abogados que representan algunas de las personas por antes mencionadas o por entidades u otras personas a través de orden judicial o en virtud de leyes federales y estatales.

Yo leo este' declaración _____ (Patient's initials)

I have read this statement to the patient _____ (Clinic staff person's initials)

NOTE: Hmong and Somali Translation of Tennessen Warning Disclosure are on page three.

Ogeysiin Digniin ah ee Loo yaqaan Tennessen (Somali)

Qoraalkani wuxuu ku saabsan yahay sidii loo heli lahaa akhbaar caafimaad oo la xiriirta tirada sunta rasaasta ee baarida caafimaadka dhiiga lagu helay iyo sidii loo qiimayn lahaa oo loo yareyn lahaa tirada suntan rasaasta ee dhiga qofka ku jirta.War bixintan Waaxda Caafimaadka iyo Caawinta Qoyska ee Minnepolis (Waaxda) ama/iyo ururada bulshada ee la shaqeeya ay qofka ka codsanyaan waa war noqon kara war qofka shakhsi u ah (private information) markii loo tixraaco sharciga Minnesota oo Nidaamka Diwaan Gelinta (Minnesota Data Practices Act) ee qodobka 13aad. Sharci ahaan qofku saxiixa qoraalkan wuu iska diidi kara. Haddii uu qofku saxiixa warqadan diido, Waaxda Caafimaadka iyo/ama ururada la shaqeeya waaxda ma siin karaan qofka macluumaadka degdega ah ee lagu qiimayn lahaa xaalada sunta rasaasta ee dhiiga laga helo. Waxaa kale oo saxiix laa'antu keeni kartaa in ay waaxda caafimaadku jawaab ka sugta laanta Caafimaadka ee Gobolka Minnesota ka hore inta aynan kula soo xiriin. Dadka akhbartan heli karaa waxa ay ka mid noqon karan, dadka ka shaqeeya qiimenta sunta rasaasta, kuwaas oo ahaan kara shaqaalaha ururaka waaxda caafimaadka, Waaxda Maamulka Sharciyada ee Minneapolis (the Minneapolis Department of Regulatory Services), Ururka Kal-kaalinta Caafimaadka ee Minnesota (the Minnesota Visiting Nurses Association), Waaxda Caafimaadka ee Minnesota (the State of Minnesota Health Department), iyo Waaxda Caafimaadka Degmada Hennepin, (the Hennepin County Department of Health). Ahkbaartan waxaa kale oo lala wadaagi kara gar-yaqaanada (attorneys) wakiilka ka ah dadka iyo ururada kor ku xusan ama qof sita tixraac amar maxkamadeed (subpoena) ama tixraac sharci waafaqsan dowlada dhaxe iyo dowlada gobolkaba (Federal and State law).

Waan akhriyay warauqdaan _____ (patient's initials)

I have read this statement to the patient _____ (Clinic staff person's initials)

Tennessen Warning Disclosure Statement (Hmong)

Daim ntawv tso caiv no xav tau ntaub ntawv txog cov hmoov txhuas, los yog lead, kom pab cov hmoov txhuas nyob rau haus ntshav qis zog. Cov ntaub ntawv npog cia no nyob rau lub tsev Minneapolis Department of Health and Family Support ("department") thiab lub tsev cov koom haum kom tes nrog lub department ("partners") nyob rau ntawm Minnesota Government Data Practices Act, Minnesota Statutues chapter 13. Yog koj tsis xav kos kom lub npe rau daim ntawv no, yuav tsis ua li cas rau koj. Yog koj tsis kos npe, lub department yuav muab tsis tau kev pab sai li sai tau rau koj. Tsis tas li ntawv, lub department yuav tsum tau tos seb koj cov ntaub ntawv pom tham ua tas ntawm cov hmoov txhuas yog li cas vim lub lav Minnesota yuav yog tus tau txais cov ntaub ntawv nos ua ntej. Cov neeg tau cov ntaub ntawv khaws tseg yog cov neeg ua hauj lwm rau cov koom haum kom tes nrog lub department, Minnesota Department of Regulatory Services, Minnesota Visiting Nurses Association, State of Minnesota Health Department thiab Hennepin County Department of Health. Cov ntaub ntawv khaws tseg no yuav mus rau neeg hais plaug ntug thiab ua hauj lwm nrog cov hoov kas sau toj no.

Kuv twb tau nyeem nriav ntawm no lawm, _____ (Sau npe, patient's initials)

I have read this statement to the patient _____ (Clinic staff person's initials)