

**ELEVATED BLOOD LEAD REPORTING FORM**

**Reporting Method and Date:**  
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<b>Patient's Name (Last) (First) (MI)</b>			<b>Telephone</b>	<b>Date of Birth</b>	<b>Age Sex</b>
<b>Patient's Address (Street)</b>		<b>(City)</b>	<b>(State)</b>	<b>(Zip Code)</b>	<b>(County)</b>
<b>Parent/Guardian Name (If applicable)</b>			<b>Other Telephone (If applicable)</b>		
<b>Possible Source of Lead Exposure (If known):</b>		<b>Other children/pregnant woman in household (Names/ DOB)</b>			
<b>Race:</b> <input type="checkbox"/> Native American/Native Alaskan <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other <b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <b>Language</b> _____					
<b>Name of Provider Ordering Test</b>				<b>Telephone</b>	
<b>Provider's Address (Street)</b>		<b>(City)</b>	<b>(State)</b>	<b>(Zip Code)</b>	<b>(County)</b>
<b>Reporting Laboratory: Name</b>			<b>Testing Laboratory Phone:</b>		
<b>Address:</b>					
<b>Date Sample Drawn:</b> ____/____/____	<b>Lab Sample No:</b>	<b>TEST RESULTS</b>		<b>Sample Type:</b>	
<b>Date Sample Analyzed:</b> ____/____/____		<b>Lead</b>  <b>µg/dL</b>	<b>ZPP (If applicable)</b>	<input type="checkbox"/> Venous  <input type="checkbox"/> Capillary	
<b>Occupational Monitoring?</b> ____ Yes ____ No ____ Unknown	<b>Employer's Name</b>		<b>Employee's Occupation</b>		
<b>Children/Pregnant Women in Home:</b> ____ Yes ____ No ____ Unknown	<b>Possible Source of Lead Exposure (If known):</b>			<b>NAICS code:</b>	

**NOTES:**