BLOOD LEAD REPORTING FORM

Report all non-elevated blood lead levels (less than 3.5 µg/dL) within one week.

Patient Name (Last) (First) (MI)	Date of Birth	Gender
Patient Address (Street) (City) (State) (Zip Code) (County)		
Telephone	Parent/Guardian	

Race: ☐ Native American/Native Alaskan ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Name of Provider Ordering Test	Provider Telephone
Provider Address (Street) (City) (State) (Zip Code) (County)	
Reporting Laboratory	Laboratory Phone

Date Sample Drawn	Sample No	TEST RESULTS		Sample Type
Date Sample Analyzed		Blood Lead µg/dL	ZPP	☐ Venous ☐ Capillary

Occupational Monitoring? ______Yes ______No _____Unknown	Employer	Occupation
Possible Source of Lead Exposure?	Children/Pregnant Women in Home? ______Yes ______No _____Unknown	
Name/DOB of other children/pregnant woman in household	Name(s)	DOB(s)

NOTES:

Lead Poisoning Prevention Program
(P) 971-673-0440; (F) 971-673-0457
leadprogram@odhsoha.oregon.gov
healthoregon.org/lead