Blood Lead Level Reporting

FOR OFFICE USE ONLY	
DOH ID Number	Date Received

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial)		Telephone
Street Address		
City	State	Zip
County	Age	Date of Birth

Sex ☐ Male ☐ Female ☐ Unknown

Race ☐ American Indian or Alaskan Native ☐ African American ☐ Caucasian ☐ Asian or Pacific Islander ☐ Unknown ☐ Other:_____	Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

☐ Refugee ☐ Immigrant ☐ International Adoptee	If yes, country from	Arrival Date

PROVIDER INFORMATION

Medical Provider		Telephone
Clinic Name and Street Address		County
City	State	Zip

LABORATORY RESULTS

Reporting Laboratory	Telephone
Laboratory Performing Tests (If different from reporting laboratory)	Telephone

Date Sample Received	Blood Lead Level µg/dl	Sample Type ☐ Venous ☐ Capilliary ☐ Unknown

OTHER INFORMATION

Reason for Test ☐ Childhood Screening ☐ Clinical Suspicion ☐ Occupational Monitoring ☐ Unknown ☐ Other:	Follow-up Test ☐ Yes ☐ No ☐ Unknown
Occupation (If patient is more than 15 yrs; Of parents if less than 15 yrs)	Industry
Employer (If patient is more than 15 yrs; Of parents if less than 15 yrs)	Telephone

MAIL or FAX COMPLETED FORM TO:	FOR MORE INFORMATION:
Washington State Department of Health PO Box 47846 Olympia, WA 98504-7846 Fax: 360-236-3059	Call 1-800-909-9898 (Toll Free in WA) http://www.doh.wa.gov/ehp/lead

Washington State Department of Health

DOH 334-153 June 2009