Blood Lead Testing
Demographic Information Form

This form must be completed and submitted with the requisition when requesting Blood Lead test as required by all Health Departments.

PLEASE PRINT CLEARLY

CHILDHOOD BLOOD LEAD (Ages 15 years old and younger)			
Required Patient Information	Last Name:	First Name:	MI
	Date of Birth: ____/____/____	Sex/Gender: Male Female	
	Street Address:	Apt. No. (if any)	
	City:	State: Zip:	
	County:	Phone #: ( ) ______ - ________	
	Race/Ethnicity: (please circle one) 1. White/Caucasian 2. Black/African American 3. Hispanic 4. Asian	5. Pacific Islander 6. American Indian 7. Other 8. Unknown	
Medicaid # (if applicable)			
Parent or Guardian	Last Name:	First Name: MI Phone	
Specimen Collection	Date specimen Collected: ____/____/____	Blood Sample Type: (please circle one) 1. Venous 2. Capillary	
ADULT BLOOD LEAD			
Required Patient Information	Last Name:	First Name:	MI
	Date of Birth: ____/____/____	Sex/Gender: Male Female	
	Street Address:	Apt. No. (if any)	
	City:	State: Zip:	
	County:	Phone #: ( ) ______ - ________	
	Race/Ethnicity: (please circle one) 1. White/Caucasian 2. Black/African American 3. Hispanic 4. Asian	5. Pacific Islander 6. American Indian 7. Other 8. Unknown	
Specimen Collection	Date specimen Collected: ____/____/____	Blood Sample Type: (please circle one) 1. Venous 2. Capillary	
Employee Information	Company Name:		
	Street Address:	City:	
	State:	Zip: Phone Number: ( ) ______ - ________	
	Physician Signature: ________________________		