PCL ALVERNO

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 5. Pacific Islander 2. Black/African American 6. American Indian 3. Hispanic 7. Other 4. Asian 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 5. Pacific Islander 2. Black/African American 6. American Indian 3. Hispanic 7. Other 4. Asian 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: _____	