

Chapter DHS 181

APPENDIX A

DEPARTMENT OF HEALTH SERVICES
 Division of Public Health
 BEH 7142(3/00)

STATE OF WISCONSIN
 Childhood Lead Poisoning Prevention Program

BLOOD LEAD LAB REPORTING FORM

Information to be provided by the Health Care Provider

(Physician, Nurse, Hospital Administrator, Local Health Officer, Director of Blood Drawing Site)

Patient Name (Last) _____ (First) _____ (Middle Initial) _____		
Date of Birth (mm/dd/yy) / /	Medical Assistance Number (if applicable)	Gender (Circle One): Male / Female
Race (Please check appropriate box)		
Native American <input type="checkbox"/>	Black <input type="checkbox"/>	Unknown <input type="checkbox"/>
Asian/Pacific Islander <input type="checkbox"/>	White <input type="checkbox"/>	(Please Specify) _____
Ethnicity (Please check appropriate box)		
Hispanic/Latin <input type="checkbox"/>	Non-Hispanic/Non-Latino <input type="checkbox"/>	Unknown <input type="checkbox"/>
Patient Street Address _____		Apt _____
City _____	County _____	State _____ Zip _____
Parent or Guardian (if patient is under 18 years of age) (Last) _____ (First) _____ (Middle Initial) _____		
Telephone Number (Or Parent or Guardian telephone number if patient is under 18 years of age) home () _____ - _____ work () _____ - _____		
Employer Name and Address (if patient is 16 years of age or older)		Occupation _____
Name of Health Care Provider _____ Address _____ Phone () _____ - _____		
Patient's Physician (if other than Health Care Provider) _____ Address _____ Phone () _____ - _____		
ADDITIONAL INFORMATION TO BE PROVIDED BY THE LABORATORY		
Laboratory Name _____		Clinical laboratory improvement amendments number: _____
Address: _____		Phone: () _____ - _____
Blood Collection Type (check one)	Venous <input type="checkbox"/>	Capillary <input type="checkbox"/>
		Date of Collection (mm/dd/yr) / /
Date of Analysis (mm/dd/yr) / /	Results _____ <u>micrograms lead per 100 milliliters of blood</u>	

If test results indicate 45 or more micrograms lead per 100 milliliters of blood, send this form immediately by fax to 608-267-0402. Return all forms to: Terri Dolphin, DHS-Division of Public Health, P. O. BOX 2659, Madison, WI 53701-2659.