

**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.