Chapter HFS 181

APPENDIX A

DEPARTMENT OF HEALTH AND FAMILY 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 ☐ Black ☐ Unknown ☐

Asian/Pacific Islander ☐ White ☐ (Please Specify) _____

Ethnicity (Please check appropriate box)

Hispanic/Latin ☐ Non–Hispanic/Non–Latino ☐ Unknown ☐

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 ☐	Capillary ☐	Date of Collection (mm/dd/yr) / /
Date of Analysis (mm/dd/yr) / /	**Results** ___ **micrograms lead per 100 milliliters of blood**		

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, DHFS–Division of Public Health, P. O. BOX 2659, Madison, WI 53701–2659.