

Chapter DHS 181

APPENDIX A

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

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 _____ 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, DHS-Division of Public Health, P. O. BOX 2659, Madison, WI 53701-2659.