

**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 ( ) _____ - _____								
<b>ADDITIONAL INFORMATION TO BE PROVIDED BY THE LABORATORY</b>								
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) / /			<b>Results</b> _____ <b><u>micrograms lead per 100 milliliters of blood</u></b>					

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.