

BLOOD LEAD REPORT FORM P.O. Box 64975, St. Paul, MN 55164-0975

Phone: (651) 201-5000 Fax: (651) 201-4909

PATIENT INFORMATION:						
LAST NAMEF			FIR	IRST NAME		MI
STREET ADDRESS			CITY		STATE_	ZIP
COUNTY	PHON	NE_()		BIRTHDATE	E/	
GENDER (circle one)	PATIENT' (circle as ma	'S RACE any as appropriate)				PATIENT'S ETHNICITY (circle one)
(1) Male	(1) American Indian, Eskimo (4) W		(4) Wh	nite	(1) Hispanic
(2) Female	or Aleut	tian (5) Nat		tive Hawaiian	(2) Non-hispanic
	(2) Asian	or (Other Pacific Islander	(9) Unknown
	(3) Black		(9) Unl	known		
GUARDIAN NAME (if child patient) ADULT PATIENT'S EMPLOYER*						
(Last Name) (First Name)						
TEST INFORMATION: DATE BLOOD TESTCapillary DRAWN//_ ANALYZED//_ LEAD RESULT · μg/dL TYPEVenous						
ANALYSIS LAB INFORMATION:				HEALTH CARE PROVIDER INFORMATION:		
LAB NAME				PHYSICIAN NAME		
ADDRESS				CLINIC NAME		
CITY STATE				ADDRESS		
ZIP	PHONE .	_()		CITY		STATE
				ZIP	PHONI	E _()
*Not Required						
Under the Minnesota Data Practices Act, the information requested on this form must be kept private by any health department staff who receive it. A report of an elevated blood lead level may be reported to a local health department for follow-up. Summaries of blood lead data are reported to the Legislature to describe the extent of lead poisoning in Minnesota. Refusal by a patient or a parent of a patient to provide this information will not affect the eligibility of the patient to receive any benefits.						
Minnesota Statutes, section 144.9502, requires medical laboratories to report all blood lead analyses and related information to the Minnesota Department of Health.						
Please mail completed form to: MN Department of Health EIA - Blood Lead Surveillance P.O. Box 64975 St. Paul, MN 55164-0975						
	OR Fax to:	(651) 201-4909	14-07/3			

12/07/2005

Print this form via our website at: http://www.health.state.mn.us/divs/eh/lead/surv/labreport.pdf