MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BLOOD LEAD ANALYSIS REPORT
DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE # R325.9082 AND R 325.9083

PATIENT INFORMATION

To be completed by Parent/Guardian or Patient
PLEASE PRINT

Last Name _____ First Name _____ M. Initial _____

Address – No PO Boxes, please _____ Apt. # _____ City _____ State MI Zip _____

Area Code and Phone Number ( )_____ Birthdate (month/day/year) _____ Parent/Guardian Name (please print) _____

Race (Check all that apply):
- □ American Indian or Alaskan Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ White
- □ Hispanic or Latino
- □ Middle Eastern or Arabic

Sex:
- □ Male
- □ Female

Funding Sources:
- □ Self Pay/Insurance
- □ Medicaid

ID# (Medicaid only): _____

If Patient is an adult (≥ 16 years):

Employer: _____

Social Security #: _____

PROVIDER/PHYSICIAN INFORMATION

To be completed by provider's office

Clinic, Hospital or Agency Name _____ Physician name _____

Mailing Address _____ City _____ State _____ Zip _____

Area Code and Phone Number ( )_____ Fax Number _____

SPECIMEN COLLECTION INFORMATION

To be completed by person who draws specimen

Specimen Collection Date _____

Source of Specimen □ Capillary □ Venous □ Filter Paper

LABORATORY INFORMATION

To be completed by testing laboratory

Laboratory Name _____ Specimen ID Number _____

Area Code and Phone Number ( )_____ Analysis Date _____

BLOOD LEAD LEVEL in Micrograms per Deciliter _____ (round to nearest whole number, please)