State of Illinois
Illinois Department of Public Health

Report of Blood Lead Test Result

Patient's Name ______________________________
Last First Middle Initial

Parent/Guardian's Name ______________________________
Last First

Phone ____________ Date of Birth ____________ Is Patient Pregnant? ❑ Yes ❑ No

Patient's Address ______________________________ County Select

City ______________ State ______ ZIP Code ______

Medicaid Number ______________________________
(if applicable)

Sex (check appropriate box) ❑ Male ❑ Female

Race (check appropriate box)

❑ White ❑ Hispanic or Latino ❑ American Indian/Native Alaskan ❑ Unknown

❑ Black/African American ❑ Asian ❑ Native Hawaiian or other Pacific Islander

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Date of Test ____________ Type ❑ Venous ❑ Capillary Test Result ____________mcg/dL

Testing Facility Name ______________________________ Lab ID # ______ Phone ____________
(Laboratory)

Provider Name ____________ Provider ID # ______ Phone ____________

Address ______________________________

City ______________ State ______ ZIP Code ______

(If information has changed, please update below)

Clinic/Hospital ______________________________

Address ______________________________

City ______________ State ______ ZIP Code ______

____
Signature of Person Completing Form

____
Date Reported

Illinois Lead Program
525 West Jefferson Street, Third Floor
Springfield, Illinois 62761-0001
Phone: 217-782-3517 Fax: 217-557-1188
TTY (hearing impaired use only) 800-547-0466

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