**Pennsylvania Childhood Lead Report**

**Date:**

**Patient information**

|  |  |  |  |
| --- | --- | --- | --- |
| Last name: | | First name: | |
| DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ | Gender: Male □ Female □ | | |
| Race: | Ethnicity: Hispanic □ Non-Hispanic□ Unknown□ | | |
| Address: | | |  |
| Street: | | |  |
| City: | | |  |
| Zip Code: | | Patient’s Phone: | |
| Guardian’s Name: | | Guardian’s Phone: | |
| Is the patient on Medical Assistance (MA)? Yes □ No□ | | | |
| If ‘Yes’ what is the patient’s MA number? | | | |

**Physician Information**

|  |  |
| --- | --- |
| Physician Name: | |
| Physician Address: | Physician’s Phone: |
| Street: |  |
| City: |  |
| Zip Code: |  |

**Provider Information**

|  |  |
| --- | --- |
| Provider Name: | |
| Provider Address: | Provider Phone: |
| Street: |  |
| City: |  |
| Zip Code: |  |

**Lab Information**

|  |  |
| --- | --- |
| Lab Name: | |
| Lab Address: | Lab Phone: |
| Street: |  |
| City: |  |
| Zip Code: |  |

**Test Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Specimen #: | | Accession Number: | |
| Collection Date: | Received Date: | | Analysis Date: |
| Specimen Source: Venous □ Capillary□ | | | |
| **Quantitative Test Result: \_\_\_\_\_\_\_\_\_\_\_\_ µg/dL** | | | |

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| --- |
| Referral Source: |