Oregon Health Authority

ELEVATED BLOOD LEAD REPORTING FORM

Patient Name (Last) (First) (MI)	Date of Birth	Gender

Patient Address (Street) (City) (State) (Zip Code) (County)

Telephone	Parent/Guardian

Race: ☐ Native American/Native Alaskan ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Name of Provider Ordering Test	Provider Telephone

Provider Address (Street) (City) (State) (Zip Code) (County)

Reporting Laboratory	Laboratory Phone

Date Sample Drawn	Sample No	TEST RESULTS		Sample Type
Date Sample Analyzed		Blood Lead µg/dL	ZPP	Venous Capillary

Occupational Monitoring? _____Yes _____No _____Unknown	Employer	Occupation

Possible Source of Lead Exposure?	Children/Pregnant Women in Home? _____Yes _____No _____Unknown

Name/DOB of other children/pregnant woman in household	Name(s)	DOB(s)

NOTES: