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)
OR

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 Type	Blood Lead Level	Has a followup test been scheduled?
	☐ Venous		
Date Sample Analyzed	☐ Capillary	µg/dL	Date of scheduled followup test:

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

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

NOTES: