

Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- Capillary
- Venous

PATIENT: _____
last first

BIRTH DATE: ____ / ____ / ____
mm dd year SSN #: ____ - ____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____

PHONE: (____) ____ - _____ GENDER: Female Male

RACE: White Black Asian American Indian / Alaskan Native
 Native Hawaiian / Pacific Islander Unknown

ETHNICITY: Hispanic Non Hispanic Unknown

PATIENT ID #: _____

CLINICIAN: _____ CLINICIAN ID #: _____
please print last first

PHONE: (____) ____ - _____ CLINICIAN'S Signature: _____

DATE COLLECTED: ____ / ____ / ____
mm dd year

Required Information

Test Type: Initial Repeat

Risk: High Low

MEDICAID / MEDICARE INFORMATION

Patient's Medicaid/Medicare #: _____

Physician Provider #: _____

Patient's Medicaid/Medicare ICD9 Code: _____

Referring Physician # (Medipass only): _____

If insurance is primary to Medicaid / Medicare

Insured's Name: _____
please print

Insured's ID#: _____

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: ____ Zip: _____

Place Data Slip Label Here

Facility Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Enter your facility address
 Results are returned
 to this address

**Blood Lead
Test Request Form**

University Hygienic Laboratory

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