Childhood Blood Lead Level Report Form
Confidential Medical Record

Send to:	**From:**
West Virginia Department of Health Bureau for Public Health Office of Maternal, Child and Family Health Division of Infant, Child, Adolescent and Young Adult Health **Childhood Lead Poisoning Prevention Project** Phone: 1-800-642-8522 RightFax: 304-957-0120	Medical Facility: Requesting Physician: City/State/Zip: Phone: Fax:

Patient Information

Last Name: First Name: M.I.:

Date of Birth: Gender: Male Female

Guardian Name: Medicaid CHIP Pregnant Breastfeeding

Physical Address: Apartment #:

City: State: WV Zip:

Mailing Address: Apartment #:

City: State: WV Zip:

Phone Number:

Ethnicity: (*check one*) Hispanic Non-Hispanic ☐ Unknown

Child Race: (*check one*) White Black Asian or Pacific Islander Native American or Alaskan Native Multi-Racial Other ________________________

Blood Lead Level Information

Blood Lead Test Level: micrograms per deciliter (µg/dL) Blood Draw Date: ____/____/____

Type of Blood Sample: (*check one*) ☐ Initial ☐ Repeat | Source of Sample *(check one)* ☐ Capillary ☐ Venous

Testing Laboratory: Laboratory Phone: Contact Person:	**If Using Lead Care II System, Place Label Here.**

Please report all blood lead levels to the Bureau for Public Health within 7 days of testing. The West Virginia Childhood Lead Poisoning Prevention Project provides care coordination for all children 0-72 months with an elevated blood lead level.