SPECTRUM HEALTH

Pediatric Blood Lead Testing

Date Ordered	Date Collected	Time Collected	Initials Collected

PATIENT INFORMATION

Name Last First Middle Int.

Address | Phone ( ) -

City State Zip

Sex	Marital Status	Birth Date	Patient's Social Security No.

Race ❑Asian/Pacific Islander ❑Black ❑Multiracial

Provider Signature: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION (fill in completely or attach a copy of patient's insurance card)

Name (Policy Holder) ❑Self ❑ Spouse | SSN (Policy #) | Group #

Address | SSN | Recipient # (Medicaid) | Plan #

Insurance Company Name & Address ❑ PPOM ❑ HMO | Policy Holder's Employer Name & Address

Parent or Guardian Information

Parent or Guardian Name (please print): | Phone number: | Parent Social Security No.:

Please fill out all the information below.

Physician Orders :

9677 ❑ Lead Level **Diagnosis**_____

Specimen Collection Date _____ Time of Collection _____

Method of Collection (Check one) ❑ Capilary ❑ Venous

Any other pertinent information or comments:

_____

_____

Laboratory Use Only

Date of arrival in lab: _____ Date of analysis: _____

Specimen Number: _____

BLOOD LEAD LEVEL _____MICROGRAMS PER DECILITER

Performed by : Spectrum Health Toxicology Laboratory (616)267-2780

This form will supply Data/Information Required by Administrative Rule # R 325.9082 and R 325.9083