OhioHealth Laboratory Services

HEAVY METAL REPORT

***REQUIRED INFORMATION – MUST BE FILLED OUT COMPLETELY**

Result Information:
Date Result Reported _____

SPECIMEN TYPE*	RESULT	**DATE SAMPLE DRAWN***	**DATE SAMPLE ANALYZED**	**MATRIX**
C – Capillary V – Venous Z – Unknown	(Indicate Units)			B - Blood U - Urine
_____	_____ ug/dl	_____	_____	
ACCESSION NUMBER	ANALYTE	PATIENT IDENTIFICATION NUMBER		
_____	____X____ LEAD	_____		

PATIENT INFORMATION*

_____
LAST FIRST MI

_____
STREET ADDRESS

_____
CITY COUNTY ZIP

_____
DATE OF BIRTH SEX

_____
SOCIAL SECURITY NUMBER

_____ _____
HOME PHONE ALT PHONE

_____
PARENT/GUARDIAN (IF UNDER 16 YEARS OF AGE)
LAST FIRST MI

_____
MEDICAID BILLING # (12 DIGITS)

RACE/ETHNICITY OF PATIENT*

_____ **WHITE/NON-HISPANIC**

_____ **BLACK/NON-HISPANIC**

_____ **HISPANIC**

_____ **ASIAN/PACIFIC ISLANDER**

_____ **AMERICAN INDIAN/ALASKAN NATIVE**

_____ **UNKNOWN**

IF THE PATIENT IS EMPLOYED*

(16 YEARS OR OLDER)

_____
EMPLOYER NAME

_____
EMPLOYER ADDRESS

_____
CITY STATE ZIP

_____
EMPLOYER PHONE

PROVIDER INFORMATION*

PHYSICIAN

CLINIC/FACILITY NAME

ADDRESS

PHONE

REPORTED BY:

NAME _____
OHIOHEALTH LABORATORY SERVICES
614-566-1LAB (1522) 844-326-1LAB (1522) FAX 614-533-1FAX (1329)

RESULTS WILL BE REPORTED TO:

LEAD PROGRAM FAX # 614-728-6793

OHIO DEPARTMENT OF HEALTH
ATTN: LEAD PROGRAM, 6TH FLOOR
P O BOX 118
COLUMBUS OHIO 43266 - 0118