bellinhealth

Bellin Health Special Chemistry
215 North Webster Avenue ◆ Green Bay, WI 54301
(920) 433-7465

BLOOD LEAD PATIENT INFORMATION SHEET

In accordance with the laws of the State of Wisconsin, the following information **must** be provided by the Health Care Provider when requesting a blood lead test. All results will be forwarded to the Department of Health and Family Services – Division of Public Health.

PATIENT NAME: _____
Last Name First Name MI

PATIENT'S STREET ADDRESS: _____ **APT. #:** _____

CITY: _____ **COUNTY:** _____ **STATE:** _____ **ZIP CODE:** _____

DATE OF BIRTH (mm/dd/yy): _____ / _____ / _____

MEDICAL ASSISTANCE NUMBER (if applicable): _____

PARENT OR GUARDIAN (if patient is under 18 years of age): _____
Last Name First Name MI

TELEPHONE NUMBER (or Parent/Guardian telephone number if patient is under 18 years of age):

Home: ( ) _____

Work: ( ) _____

RACE (please check the appropriate box):

❒ Caucasian ❒ Black ❒ Hispanic / Latin
❒ Asian / Pacific Islander ❒ Native American ❒ Hispanic / Non-Latino
❒ Unknown ❒ Other _____

EMPLOYER NAME & ADDRESS (if patient is 16 years of age or older):

Name: _____

Address: _____

_____

Telephone Number: ( ) _____ Occupation: _____

NAME & ADDRESS OF HEATLH CARE PROVIDER:

Name: _____

Address: _____

_____

Telephone Number: ( ) _____

PATIENT'S PHYSICIAN (if other than Health Care Provider):

Name: _____

Address: _____

_____

Telephone Number: ( ) _____

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