MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BLOOD LEAD ANALYSIS REPORT
DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE # R 325.9082 and R 325.9083

PATIENT INFORMATION
To be completed by Parent/Guardian or Patient
PLEASE PRINT

Last Name _____ First Name _____ Middle Initial _____

Address — No PO Boxes, please _____ Apt. # _____ City _____ State MI Zip _____

( ) _____
Area Code and Phone Number

Birthdate (month/day/year) _____

Parent/Guardian Name (please print) _____

Race (Check all that apply):
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Middle Eastern or Arabic

Sex:
- ☐ Male
- ☐ Female

Funding Sources:
- ☐ Self Pay/Insurance
- ☐ Medicaid

ID# (Medicaid only): _____

If Patient is an adult (> 16 years):

Employer: _____

Social Security #: _____

PROVIDER/PHYSICIAN INFORMATION
To be completed by provider's office

Clinic, Hospital or Agency Name _____ Physician name _____

Mailing Address _____ City _____ State _____ Zip _____

( ) _____
Area Code and Phone Number

Fax Number _____

SPECIMEN COLLECTION INFORMATION
To be completed by person who draws specimen

Specimen Collection Date _____

Source of Specimen ☐ Capillary ☐ Venous ☐ Filter Paper

LABORATORY INFORMATION
To be completed by testing laboratory

Laboratory Name _____ Specimen ID Number _____

Area Code and Phone Number _____ Analysis Date _____

BLOOD LEAD LEVEL in Micrograms per Deciliter _____ (round to nearest whole number, please)

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DCH-0395 (March 2004) Authority: Act 368, PA 1978 Fax Number (517) 335-8509