Use this form to report blood lead levels **less than 3.5 µg/dL**. Please print clearly or type.
Fax to (334) 206-3726 within 5 days of testing. Please call (334) 206-3883 with any questions. *Blood lead levels greater than or equal to (≥) 3.5 µg/dL should be reported on the report form for blood lead results ≥ 3.5 µg/dL within 5 days of testing.*

First Name			**Last Name**		
Date of Birth	**Gender**	**Race(s)**	**Ethnicity**	**Medicaid #**	
Street Address			**City**	**State**	**Zip Code**
Collection Date	**Specimen:** (Check one) ☐ **Venous** ☐ **Capillary**			**Blood Lead Level** __________ **µg/dL**	

First Name			**Last Name**		
Date of Birth	**Gender**	**Race(s)**	**Ethnicity**	**Medicaid #**	
Street Address			**City**	**State**	**Zip Code**
Collection Date	**Specimen:** (Check one) ☐ **Venous** ☐ **Capillary**			**Blood Lead Level** __________ **µg/dL**	

First Name			**Last Name**		
Date of Birth	**Gender**	**Race(s)**	**Ethnicity**	**Medicaid #**	
Street Address			**City**	**State**	**Zip Code**
Collection Date	**Specimen:** (Check one) ☐ **Venous** ☐ **Capillary**			**Blood Lead Level** __________ **µg/dL**	

First Name			**Last Name**		
Date of Birth	**Gender**	**Race(s)**	**Ethnicity**	**Medicaid #**	
Street Address			**City**	**State**	**Zip Code**
Collection Date	**Specimen:** (Check one) ☐ **Venous** ☐ **Capillary**			**Blood Lead Level** __________ **µg/dL**	

First Name			**Last Name**		
Date of Birth	**Gender**	**Race(s)**	**Ethnicity**	**Medicaid #**	
Street Address			**City**	**State**	**Zip Code**
Collection Date	**Specimen:** (Check one) ☐ **Venous** ☐ **Capillary**			**Blood Lead Level** __________ **µg/dL**	

Reporting Facility____

Name of Sender____ Phone________________________________