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 μ g/dL should be reported on the report form for blood lead results > 3.5 μ g/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	Blo	od Lead Level	μg/dL

First Name		Last I	Name				
Date of Birth	Gender	Race(s)		Ethnicity	М	edicaid #	
Street Address				City		State	Zip Code
Collection Date	Specimen:	(Check one) _	Venous	Capillary	Bl	ood Lead Level _	μg/dL

First Name		La	st Name						
Date of Birth	Gender	Race(s)	e(s)		icity	Medicaid #			
Street Address				City			State	Zip Code	
Collection Date	Specimen:	(Check one	e)Venous	sCa	pillary	Blo	od Lead Level _		µg/dL

First Name		Las	Name					
Date of Birth	Gender	Race(s)		Ethnicity	Μ	Medicaid #		
Street Address				City		State	Zip Code	
Collection Date	Specimen:	(Check one)	Venous	sCapillary	Bl	ood Lead Level _	μg/dL	

First Name		Last N	ame				
Date of Birth	Gender	Race(s)		Ethnicity	1	Aedicaid #	
Street Address	·		(City		State	Zip Code
Collection Date	Specimen:	(Check one)	Venous	Capillary	E	Blood Lead Level _	μg/dL

Reporting Facility_____

Name of Sender_____ Phone_____ Phone_____

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