

Use this form to report all **elevated blood lead levels** greater than or equal to 3.5 µg/dL. Please print or type.

Fax to (334) 206-3726 within 5 days of testing. Please call (334) 206-3883 with any questions.

Blood lead levels less than 3.5 µg/dL should be reported on the non-elevated blood lead reporting form within 30 days of testing.

| | | | | |
|------------------------|---|-------------------|--|-----------------|
| Last Name | | First Name | | |
| Date of Birth | Gender | Race(s) | Ethnicity | |
| Street Address | | City | State | Zip Code |
| Parent/Guardian | | Phone | | |
| Collection Date | Specimen: ___ Venous (Check one) ___ Capillary | | Blood Lead Level _____ µg/dL | |
| Medicaid Number | Other Comments | | | |

| | | | | |
|------------------------|---|-------------------|--|-----------------|
| Last Name | | First Name | | |
| Date of Birth | Gender | Race(s) | Ethnicity | |
| Street Address | | City | State | Zip Code |
| Parent/Guardian | | Phone | | |
| Collection Date | Specimen: ___ Venous (Check one) ___ Capillary | | Blood Lead Level _____ µg/dL | |
| Medicaid Number | Other Comments | | | |

Reporting Facility _____

Name of Sender _____ Phone _____