MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BLOOD LEAD ANALYSIS REPORT
DATA/INFORMATION REQUIRED BY ADMINISTRATIVE RULE # R325.9082 AND R 325.9083

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

Last Name ____________ First Name ____________ M. 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)