



BLOOD LEAD REPORT FORM
P.O. Box 64975, St. Paul, MN 55164-0975
Phone: (651) 201-5000 Fax: (651) 201-4909

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

COUNTY _____ PHONE (____) _____ - _____ BIRTHDATE ____/____/____

GENDER (circle one)	PATIENT'S RACE (circle as many as appropriate)	PATIENT'S ETHNICITY (circle one)
(1) Male	(1) American Indian, Eskimo or Aleutian	(1) Hispanic
(2) Female	(2) Asian	(2) Non-hispanic
	(3) Black	(9) Unknown
	(4) White	
	(5) Native Hawaiian or Other Pacific Islander	
	(9) Unknown	

GUARDIAN NAME (if child patient) _____ ADULT PATIENT'S EMPLOYER* _____
 (Last Name) (First Name)

TEST INFORMATION:

DATE DRAWN ____/____/____ DATE ANALYZED ____/____/____ BLOOD LEAD RESULT ____ . ____ μg/dL TEST TYPE ____ Capillary Venous

ANALYSIS LAB INFORMATION:

LAB NAME _____
 ADDRESS _____
 CITY _____ STATE _____
 ZIP _____ PHONE (____) _____ - _____

HEALTH CARE PROVIDER INFORMATION:

PHYSICIAN NAME _____
 CLINIC NAME _____
 ADDRESS _____
 CITY _____ STATE _____
 ZIP _____ PHONE (____) _____ - _____

*Not Required

Under the Minnesota Data Practices Act, the information requested on this form must be kept private by any health department staff who receive it. A report of an elevated blood lead level may be reported to a local health department for follow-up. Summaries of blood lead data are reported to the Legislature to describe the extent of lead poisoning in Minnesota. Refusal by a patient or a parent of a patient to provide this information will not affect the eligibility of the patient to receive any benefits.

Minnesota Statutes, section 144.9502, requires medical laboratories to report all blood lead analyses and related information to the Minnesota Department of Health.

Please mail completed form to: **MN Department of Health**
EIA - Blood Lead Surveillance
P.O. Box 64975
St. Paul, MN 55164-0975
 OR Fax to: **(651) 201-4909**