State of Illinois
Illinois Department of Public Health

Report of Blood Lead Test Result

Patient's Name _____
Last First Middle Initial

Parent/Guardian's Name _____
Last First

Phone _____ Date of Birth _____ Is Patient Pregnant? ❑ Yes ❑ No

Patient's Address _____ County Select

City _____ State _____ ZIP Code _____

Medicaid Number _____ Sex (check appropriate box) ❑ Male ❑ Female
(if applicable)

Race (check appropriate box)
❑ White ❑ Hispanic or Latino ❑ American Indian/Native Alaskan ❑ Unknown
❑ Black/African American ❑ Asian ❑ Native Hawaiian or other Pacific Islander

Date of Test _____ Type ❑ Venous ❑ Capillary Test Result _____mcg/dL

Testing Facility Name _____ Lab ID # _____ Phone _____
(Laboratory)

Provider Name _____ Provider ID # _____ Phone _____

Address _____

City _____ State _____ ZIP Code _____

(If information has changed, please update below)

Clinic/Hospital _____

Address _____

City _____ State _____ ZIP Code _____

_____ _____
Signature of Person Completing Form Date Reported

Illinois Lead Program
525 West Jefferson Street, Third Floor
Springfield, Illinois 62761-0001
Phone: 217-782-3517 Fax: 217-557-1188
TTY (hearing impaired use only) 800-547-0466

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