

## LABORATORY REPORT OF ELEVATED BLOOD LEAD LEVELS

|  |   |   |                  |   |  |   |       |                 |            |
|--|---|---|------------------|---|--|---|-------|-----------------|------------|
| LABORATORY   |   | ARIZONA ADMINISTRATIVE CODE R9-4-301/302 REQUIRES:  |                  |   | PLEASE SUBMIT REPORT TO:   |   |       |                 |            |
| ADDRESS  |   | <b>CHILDREN &lt;16 YEARS OF AGE:</b><br>All blood lead levels of $\geq 10$ ug/dL are reportable within 5 business days. Blood lead levels $\geq 45$ ug/dL are reportable within 1 business day. |                  |   | <b>CONFIDENTIAL</b><br>LEAD POISONING PREVENTION PROGRAM<br>OFFICE OF ENVIRONMENTAL HEALTH<br>ARIZONA DEPARTMENT OF HEALTH SERVICES<br>150 NORTH 18 <sup>th</sup> AVENUE SUITE 140<br>PHOENIX, ARIZONA 85007<br>602- 364-3118 1-800-367-6412 FAX 602- 364-3146 |   |       |                 |            |
| CITY   | STATE   |   |                  |   |  |   |       |                 | ZIP        |
| PHONE  | DIRECTOR  |   |                  | PLEASE SUBMIT REPORT BY PHONE, MAIL OR FAX. IF FAXED, PLEASE CALL AHEAD TO ENSURE CONFIDENTIALITY   |  |   |       |                 |            |
|   |   |   |                  |   |  |   |       |                 |            |
| LAST NAME  |   | FIRST   | DOB              | ADDRESS   |  | CITY  | STATE | ZIP             | HOME PHONE |
| DATE COLLECTED   | TEST DATE   | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE  |                  | RACE* <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN<br>ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC |  |   |       |                 |            |
| BLOOD LEAD LEVEL<br>_____ ug/dL  | <input type="checkbox"/> VENOUS<br><input type="checkbox"/> CAPILLARY | PHYSICIAN LAST NAME   |                  | FIRST   | CLINIC   | PHYSICIAN ADDRESS                                     |       | PHYSICIAN PHONE |            |
| <input type="checkbox"/> AHCCCS <input type="checkbox"/> KIDS CARE <input type="checkbox"/> INDIAN HEALTH SERVICES <input type="checkbox"/> TOBACCO TAX<br><input type="checkbox"/> SELF-PAY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> OCCUPATIONAL MONITORING |   |   | HEALTH PLAN NAME |   | HEALTH PLAN ID#  | ADULTS: OCCUPATION, BUSINESS NAME, ADDRESS, AND PHONE |       |                 |            |
| LAST NAME  |   | FIRST   | DOB              | ADDRESS   |  | CITY  | STATE | ZIP             | HOME PHONE |
| DATE COLLECTED   | TEST DATE   | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE  |                  | RACE* <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN<br>ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC |  |   |       |                 |            |
| BLOOD LEAD LEVEL<br>_____ ug/dL  | <input type="checkbox"/> VENOUS<br><input type="checkbox"/> CAPILLARY | PHYSICIAN LAST NAME   |                  | FIRST   | CLINIC   | PHYSICIAN ADDRESS                                     |       | PHYSICIAN PHONE |            |
| <input type="checkbox"/> AHCCCS <input type="checkbox"/> KIDS CARE <input type="checkbox"/> INDIAN HEALTH SERVICES <input type="checkbox"/> TOBACCO TAX<br><input type="checkbox"/> SELF-PAY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> OCCUPATIONAL MONITORING |   |   | HEALTH PLAN NAME |   | HEALTH PLAN ID#  | ADULTS: OCCUPATION, BUSINESS NAME, ADDRESS, AND PHONE |       |                 |            |
| LAST NAME  |   | FIRST   | DOB              | ADDRESS   |  | CITY  | STATE | ZIP             | HOME PHONE |
| DATE COLLECTED   | TEST DATE   | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE  |                  | RACE* <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER _____ <input type="checkbox"/> UNKNOWN<br>ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC |  |   |       |                 |            |
| BLOOD LEAD LEVEL<br>_____ ug/dL  | <input type="checkbox"/> VENOUS<br><input type="checkbox"/> CAPILLARY | PHYSICIAN LAST NAME   |                  | FIRST   | CLINIC   | PHYSICIAN ADDRESS                                     |       | PHYSICIAN PHONE |            |
| <input type="checkbox"/> AHCCCS <input type="checkbox"/> KIDS CARE <input type="checkbox"/> INDIAN HEALTH SERVICES <input type="checkbox"/> TOBACCO TAX<br><input type="checkbox"/> SELF-PAY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> OCCUPATIONAL MONITORING |   |   | HEALTH PLAN NAME |   | HEALTH PLAN ID#  | ADULTS: OCCUPATION, BUSINESS NAME, ADDRESS, AND PHONE |       |                 |            |

**ADHS  
USE  
ONLY**

\* THIS INFORMATION IS ESSENTIAL FOR CASE MANAGEMENT, ALTHOUGH NOT REQUIRED BY LAW. ELECTRONIC REPORTING IS AVAILABLE. PLEASE CONTACT THE ADHS AT 602-230-5830.

**DATE RECEIVED:** \_\_\_\_\_