


LABORATORY REPORT OF ELEVATED BLOOD LEAD LEVELS

LABORATORY		ARIZONA ADMINISTRATIVE CODE R9-4-301/302 REQUIRES:			PLEASE SUBMIT REPORT TO:			
ADDRESS		CHILDREN <16 YEARS OF AGE: All blood lead levels of \$10 Fg/dL are reportable within 5 business days. Blood lead levels \$45 Fg/dL are reportable within 1 business day.			<div style="border: 1px solid black; padding: 5px; text-align: center;">  </div> CONFIDENTIAL LEAD POISONING PREVENTION PROGRAM OFFICE OF ENVIRONMENTAL HEALTH ARIZONA DEPARTMENT OF HEALTH SERVICES 150 NORTH 18 th AVENUE SUITE 430 PHOENIX, ARIZONA 85007 602- 364-3118 1-800-367-6412 FAX 602- 364-3146 TUCSON FAX 520-770-3307 PLEASE SUBMIT REPORT BY PHONE, MAIL OR FAX. IF FAXED, PLEASE CALL AHEAD TO ENSURE CONFIDENTIALITY			
CITY	STATE	ZIP	ADULTS ≥16 YEARS OF AGE: All blood lead levels of \$25 Fg/dL are reportable within 5 business days. Blood lead levels of ≥60 Fg/dL are reportable within 1 business day.					
PHONE	DIRECTOR		All results <10 Fg/dL are reportable by laboratories within 30 days.					
LAST NAME		FIRST	DOB	ADDRESS	CITY	STATE	ZIP	HOME PHONE
DATE COLLECTED	TEST DATE	<input type="checkbox"/> MALE <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 ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC					
BLOOD LEAD LEVEL _____ ug/dL	<input type="checkbox"/> VENOUS <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 <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 <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 ETHNICITY* <input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC					
BLOOD LEAD LEVEL _____ ug/dL	<input type="checkbox"/> VENOUS <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 <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
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BLOOD LEAD LEVEL _____ ug/dL	<input type="checkbox"/> VENOUS <input type="checkbox"/> CAPILLARY	PHYSICIAN LAST NAME	FIRST	CLINIC	PHYSICIAN ADDRESS	PHYSICIAN PHONE		
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PLEASE SEND WHITE COPY TO THE ADHS. RETAIN YELLOW COPY.

**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: _____
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