Baltimore City Health Department
Childhood Lead Poisoning and Prevention Program

312 N. Charles Street, 2nd Floor
Baltimore, Maryland 21201
443-984-2470

BLOOD LEAD SCREEN/CONFIRMATION

Physician	
Street	
City MD	Zip

Physician's Telephone: ______________________________

TYPE OR PRINT LEGIBLY

Patient's SS# __ __ __/__ __/__ __ __ Case # ________________________________

Patient: ____________________________________ Lab No.: __________________

Date of Birth: ___/___/___ Sex: M ☐ F ☐ Race: _______________________

Parent or Guardian's name if patient is a child: Telephone:

____ _______________________

Address: ____

City: ____________ County: ____________ State: ____________ Zip: ______

Medical Assistant No.: ____________________________________ State ☐ Federal ☐

Other Third Party: __________________________ Policy No.: _________________

Group Affiliation: ___________________________ ICD 9 Code: ________________

Individual Payer (Health Dept.) N/C ☐ A ☐ B ☐ C ☐ D ☐

Occupation (Adult): ___________ Employment Address: _______________________

Hospitalized ☐ ______________________________ Receiving Chelation Therapy ☐
Where

Date Specimen Taken: __________ Received: ___________ Reported: __________

LABORATORY REPORT

Lab Name: ____

Lab Address: ____________________________________ Phone No.: __________

Type of Specimen	Blood Lead (µg/dL)
Venous (Vacutainer)	
Capillary (Microtainer)	

Remarks:

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______________________ Analyst(s) ______________________________________