PHYSICIAN HOME INVESTIGATION REQUEST FORM

ELEVATED BLOOD LEAD LEVEL

Child's Name Last: **First:** **MI:**

Parent/Guardian's Name Last: **First:**

Phone Home: ( ) _____ Date of Birth: ____/____/____
Work: ( ) _____

Child's Address: Number Street
Unit/Apt#

County: COOK City: CHICAGO State: ILL
ZIP: 606_____

SEX: (Please check one) ( ) Male ( ) Female

Race: (Please check one) ( ) American Indian ( ) Asian ( ) Black
( ) White ( )Alaskan Native ( ) Pacific Islander ( )Native Hawaiian ( ) Other

Hispanic: (Please check one) ( ) Yes ( ) No

Date of Test: ____/____/____ Type of Test: Test Results: _____
( ) Venous
( ) Capillary

OTHER SIBLING WITH ELEVATED BLOOD LEVELS: ( ) YES ( ) NO

Testing Facility: (Laboratory) Phone: ( )

PROVIDER NAME:

ADDRESS: CITY: STATE:
ZIP:

Signature: _____ Date: ____/____/____
(Person Completing Form) (Date Reported)

CHICAGO DEPARTMENT OF PUBLIC HEALTH
LEAD POISONING PREVENTION PROGRAM
2133 West Lexington Chicago, Illinois 60612
VOICE: (312) 747 - 5323
FAX#: (312) 746 - 6526