



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 _____

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