



# CDPH Provider Home Lead Investigation Request and Lead Blood Test Notification Referral Follow-Up Form

### Services

Referral for capillary results of blood lead levels  $\geq 5\mu\text{g/dL}$  done at a community outreach event or mobile health van of which the primary health provider is unknown and a follow-up venous lead test is required.

Notification and referral for follow-up of venous blood lead levels  $\geq 45\mu\text{g/dL}$ .

Notification and referral for follow-up of a capillary blood lead level  $\geq 45\mu\text{g/dL}$  requiring a venous confirmatory test.

### Notification of Lead Test Results:

Was the parent/guardian of the child or pregnant person notified of results?  Yes  No

Was the parent/guardian of the child or pregnant person notified of referral to CDPH ?  Yes  No

**Patient Information:**  Child  Pregnant Woman

Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Patient Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: ( ) Female ( ) Male

Patient Race:  American Indian  Asian  Black  White  Other \_\_\_\_\_

Hispanic/Latin X:  Yes  No

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

Mobile Cell # ( ) \_\_\_\_\_ Home# ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_

**Client Address:** Street Number \_\_\_\_\_ Direction \_\_\_\_\_ Street Name \_\_\_\_\_

Unit/Apt # \_\_\_\_\_ Zip 606 \_\_\_\_\_, City: Chicago County: Cook State: IL

Other City of Chicago Zip Codes: 60707, 60827 **(Please call for clarification of City of Chicago boundary limits)**

### Test Results:

Current Test Date: \_\_\_/\_\_\_/\_\_\_ Type:  Venous  Capillary Test results: \_\_\_\_\_  $\mu\text{g/dL}$

Previous Test Date: \_\_\_/\_\_\_/\_\_\_ Type:  Venous  Capillary Test results: \_\_\_\_\_  $\mu\text{g/dL}$

Date current lead level reported to IDPH \_\_\_/\_\_\_/\_\_\_  Unknown

**Other Sibling (s)** with elevated blood lead levels  Yes  No

**Name of Testing Facility(Laboratory, Clinic, Hospital, Mobile Van):** \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ Provider requesting lead home inspection or follow-up: \_\_\_\_\_  
\_\_\_\_\_  
(MD, PA, NP, RN)

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # ( ) \_\_\_\_\_ Fax# ( ) \_\_\_\_\_ e-mail \_\_\_\_\_ (optional)

### Comments/ Special Instructions:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Person Completing Form)

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