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

Services

☐ Referral for capillary results of blood lead levels ≥ 5µg/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 ≥ 45µg/dL.

☐ Notification and referral for follow-up of a capillary blood lead level ≥ 45µg/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: __________µg/dL

Previous Test Date: ___/_____/_________ Type: ☐ Venous ☐ Capillary Test results: __________µg/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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