



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
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 TTY (hearing impaired use only) 800-547-0466