

BLOOD LEAD ANALYSIS

NC Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive P.O. Box 28047 Raleigh, NC 27611-8047

Patient Information	[1] Last Name	[Grid]												Attach Approved Printed Label Below																																																										
	First Name	[Grid]												MI	[Grid]																																																									
	[2] Address	[Grid]																																																																						
	Address	[Grid]																																																																						
	City	[Grid]								[3] County	[Grid]				State	[Grid]		Zip Code	[Grid]																																																					
[4] Local Pt. ID	[Grid]												SSN	[Grid]				[5] Date of Birth (MM/DD/CCYY)	[Grid]		/	[Grid]		/	[Grid]																																															
[6] Medicaid Client	<input type="checkbox"/> Yes		[Grid]										[7] Dx Code/ICD	[Grid]												<input type="checkbox"/> No																																														
[8] Race (mark all that apply)	<input type="checkbox"/> White												<input type="checkbox"/> American Indian/Alaska Native												<input type="checkbox"/> Black												<input type="checkbox"/> Native Hawaiian/Pacific Isles												<input type="checkbox"/> Asian												<input type="checkbox"/> Unknown											
[9] Ethnicity	<input type="checkbox"/> Hispanic												<input type="checkbox"/> Non-Hispanic												<input type="checkbox"/> Unknown																																															
[10] Sex	<input type="checkbox"/> Male												<input type="checkbox"/> Female																																																											
[11] Other (mark all that apply)	<input type="checkbox"/> Refugee (up to 16 years of age, see definition below)												<input type="checkbox"/> Child (up to 6 years of age)												<input type="checkbox"/>												<input type="checkbox"/> WIC Patient																																			
Specimen	[12] ESSENTIAL SPECIMEN DATA	Date Collected (MM/DD/CCYY) [Grid]												[13] EIN / Federal Tax Number [Grid]																																																										
	<input type="checkbox"/> Microtainer													EIN / Federal Tax Number, including letter suffix (if assigned), that is registered with the State Laboratory of Public Health MUST be included for specimen to be processed.																																																										
	<input type="checkbox"/> Venous													Name _____																																																										
<input type="checkbox"/> Initial blood lead test													LAB												[12] Lab Use Only												[13] Bar Code																																			
<input type="checkbox"/> Follow-up blood lead test																									[Grid]												[Grid]																																			
																																				<input type="checkbox"/> Specimen Missing																																				
																																				<input type="checkbox"/> Submitter info not provided																																				
																																				Unsat Code _____																																				

INSTRUCTIONS

PURPOSE: To identify children up to 6 years of age with elevated blood lead levels.

PREPARATION OF SPECIMEN: Collect specimen following instructions in "SCOPE, A Guide to Services" on our website at <http://slph.ncpublichealth.com>, using recommended collection kits. Label each tube with patient's name and date of birth; refrigerate until shipped. Fill out this form and mail in appropriate mailer with the specimen to the State Laboratory of Public Health. Do not send without patient information on specimen or without a form.

PREPARATION OF FORM: Do Not Photocopy. Forms must be printed on plain white paper from our website at <http://slph.ncpublichealth.com>. For optimum accuracy, please print in capital letters and avoid contact with the edge of the boxes.

- [1] Enter patient's name, last name, first name and middle initial. Only approved labels may be used as an alternative.
- [2] Enter patient's home address on lines immediately below. This information is required for epidemiologic follow-up.
- [3] Enter county of residence of the patient (Health Departments use county code).
- [4] Enter patient number (SSN or other unique number).
- [5] Enter date of birth (not age).
- [6] Indicate if patient is a Medicaid client; if yes, enter Medicaid number.
- [7] Enter Diagnosis Code or ICD-9 Code number.
- [8], [9] and [10]. Indicate race, Hispanic ethnicity, and sex by checking the appropriate box. These data are for statistical purposes only.
- [11] Indicate if patient is a Refugee, Child, Prenatal or a WIC client.
- [12] Enter date the specimen is collected, Microtainer or Venous sample and Initial or Follow-up test.
- [13] Enter submitter federal tax number (EIN), including letter suffix (if assigned), that is registered with the State Laboratory of Public Health.

Refugee – person up to 16 years of age who has had to flee his/her country because of a well-founded fear of persecution for race, religion, nationality, political opinion or membership in a particular social group; most likely he/she cannot or are afraid to return to his/her homeland. Refugee is a legal and documented immigration status in the United States.

DISPOSITION: This form may be destroyed in accordance with Standard 5, Patient Clinical Records, of the Records Disposition Schedule published by the N.C. Division of Archives and History.