Requisition for Blood Lead Test H-444

Only one specimen per form.
Please refer to Test Reference Manual and Fee Schedule for more information:
milwaukee.gov/health/testing-Fees

City of Milwaukee Health Department Laboratory
841 N. Broadway, Rm. 205, Milwaukee, WI 53202-3653
Phone: (414) 286-3526 FAX: (414) 286-5098
email: mhdlab@milwaukee.gov web: milwaukee.gov/healthlab

PATIENT INFORMATION *(required)*

Last Name: _____ First Name:_____ MI: _____

Date of Birth *(mm/dd/yyyy):* _____/_____/_____ Social Security Number:_____-_____-_____

Street Address: _____ City/State/Zip:_____

Phone:_____

Gender: ☐ M ☐ F ☐ M→F ☐ F→M ☐ Other

Race: ☐ White ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ Native American/Native Alaskan ☐ Asian ☐ Unknown

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown

GUARDIAN INFORMATION *(required)*

Last Name: _____ First Name:_____ MI: _____

Relationship to Child:_____

Street Address: (If different from child) _____ City/State/Zip: _____

Cell / Work / Other Phone: _____

SPECIMEN & TEST REQUEST INFORMATION

☐ Blood lead

Select sample type:
☐ Capillary
☐ Venous

Date Collected: _____ / ____ /_____ Time:_____
mm dd yyyy

HHLPSS ID#_____

DIAGNOSIS

Clinical Diagnosis:_____

Date of onset: _____ / ____ /_____
mm dd yyyy

SIGNIFICANT FACTORS

Describe:_____

_____

MEDICAL COVERAGE

☐ Medicaid Number (10-digit): _____

HMO Name: _____

☐ Private Medical Insurance

☐ No Medical Coverage

YOUR FACILITY *Enter your facility address. Results are returned to this address.*

Facility Name: _____

Physician _____

Address: _____

City/State/Zip:_____

Phone:_____ Fax: _____

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