☐ Acceptance Criteria Not Met
Reason: ____________________
Date: __________ Initials: _______

BLOOD LEAD ANALYSIS

NC Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive Raleigh, NC 27607

Patient Information

[1]
Last Name
First Name MI

Attach Approved Printed Label Below

[2]
Address
Address
City

[3]
County State Zip Code

[4] Local Pt. ID
[5] Date of Birth (MM/DD/CCYY) / /

[6] Medicaid Client If yes, enter # ☐ Yes ☐ No
[7] Dx Code/ICD

Insurance ID Number (if applicable):

[8] Race (mark all that apply)
☐ White ☐ American Indian/Alaska Native
☐ Black ☐ Native Hawaiian/Pacific Isles
☐ Asian ☐ Unknown

[9] Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

[10] Sex
☐ Male
☐ Female

[11] Other (mark all that apply)
☐ Refugee (up to 16 years of age, see definition below)
☐ Child (up to 6 years of age)
☐ Prenatal
☐ WIC Patient

Specimen

[12] ESSENTIAL SPECIMEN DATA

Collection Time (24hr time)

Date Collected (MM/DD/CCYY) / /

☐ Microtainer ☐ Initial blood lead test
☐ Venous ☐ Follow-up blood lead test

[13] EIN / Federal Tax Number

-

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.

Name ____________________

[14]
NPI Number
Ordering Provider Last Name
Ordering Provider First Name

LAB

Lab Use Only Bar 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.dph.ncdhhs.gov, using recommended collection kits. Label each tube with patient's name and date of birth. 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.dph.ncdhhs.gov/. 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.
[5] Enter date of birth (not age).
[6] Indicate if patient is a Medicaid client; if yes, enter Medicaid number and Insurance ID 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 and time 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.