GEORGIA DEPARTMENT OF PUBLIC HEALTH
PUBLIC HEALTH LABORATORY

BLOOD LEAD SUBMISSION FORM

SUBMITTER INFORMATION

SUBMITTER CODE:

☐☐☐☐☐☐

CLINIC NAME _____

_____

STREET: _____

_____

CITY: _____

STATE _____ ZIP CODE:_____

PHONE NO: _____

FAX NO: _____

CONTACT NAME:

_____

PATIENT INFORMATION

PATIENT ID # _____ DATE OF BIRTH: _____/_____/_____

NAME: _____
Last First Middle Initial

ADDRESS: _____

CITY: _____ STATE: _____

COUNTY: _____ ZIP CODE: _____-_____

RACE:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African-American
☐ Native Hawaiian/Pacific Islander
☐ Other
☐ Unknown
☐ White

ETHNICITY:
☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Unknown

GENDER:
☐ Male
☐ Female
☐ Unknown

SPECIMEN INFORMATION

DATE COLLECTED: _____/_____/_____ COLLECTION METHOD: ☐ CAPILLARY ☐ VENOUS

REASON FOR TEST: ☐ SCREEN ☐ CONFIRMATION ☐ FOLLOW-UP ☐ OTHER: _____

Form 3583 (Rev. 11/22/2011)