MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
MISSOURI STATE PUBLIC HEALTH LABORATORY
BLOOD LEAD TEST REQUEST

101 NORTH CHESTNUT STREET, PO BOX 570
JEFFERSON CITY, MO 65101
(573) 751-3334
http://health.mo.gov/lab/index.php

Accession Number Barcode
(For SPHL use only)

TEST REQUESTED

SPECIMEN TYPE ☐ Venous ☐ Capillary | DATE COLLECTED (YYYY/MM/DD) | SPECIMEN ID (SUBMITTERS SPECIMEN ID)

PATIENT INFORMATION (REQUIRED)

PATIENT LAST NAME | PATIENT FIRST NAME

BIRTH DATE (YYYY/MM/DD) | ADDRESS

CITY | STATE | ZIP CODE | TELEPHONE NUMBER

GENDER ☐ Female ☐ Male

ETHNICITY ☐ Hispanic ☐ Non Hispanic ☐ Unknown

RACE ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown

ORDERING CLINICIAN INFORMATION

LAST NAME | FIRST NAME

CLINICIAN FACILITY NAME | TELEPHONE NUMBER

ADDRESS | CITY | STATE | ZIP CODE

SUBMITTER INFORMATION (RESULTS ARE RETURNED TO THIS ADDRESS)

NUMBER | NAME

ADDRESS | CITY | STATE | ZIP CODE

SUBMITTER CONTACT NAME | SUBMITTER TELEPHONE NUMBER | OUTREACH EVENT

ADDITIONAL PATIENT INFORMATION

PARENT/GUARDIAN LAST NAME | PARENT/GUARDIAN FIRST NAME | PARENT/GUARDIAN DAYTIME PHONE NUMBER

REASON FOR LEAD SCREENING

☐ Routine Screening ☐ Confirmatory Venous ☐ Follow-up ☐ Symptoms of Lead Poisoning ☐ Other: _____

☐ Prenatal Screening ☐ Occupational ===> Employer's Name: _____

BILLING INFORMATION - Submitter will be billed $16.50 per sample. No fee will be charged for Medicaid clients and LPHAs.

PAYMENT SOURCE

☐ Private Insurance ☐ Personal Pay ☐ Medicaid ☐ Unknown ☐ Unable to Pay*

MEDICAID NUMBER/DCN __|__|__|__|__|__|__|__

_____

*PROVIDER SIGNATURE ATTESTING CLIENTS INABILITY TO PAY.

Refusal of Blood Lead Testing Form

*Child Care Facility Name:*_____

*Facility Address:*_____

*Facility Director/Staff Member/Case Manager:*_____

Contact Numbers: *Phone:(___)____-_____* *Fax:(___)____-_____*

Parent/Guardian Refusal of Blood Lead Testing

Print Child's Full name: _____

Child's Date of Birth: _____

I verify that I have been made aware of the serious and long-term health effects of lead poisoning on children under the age of six years. I do object to my child being blood tested in order to determine if he/she is lead poisoned, and hereby refuse blood lead testing. I am aware that a copy of this refusal will be sent to my child's primary care physician.

Reason for Refusal: _____

Signed _____ **Relation to child:** _____ **Date:** _____
(parent or guardian)

Parent/Guardian Address:

_____
Street Address **City,** **State** **Zip**

Parent /Guardian Phone number: _____

Child's Physician Name: _____

Child's Physician Address: _____

_____

_____

Copies: Provide parent/Guardian with 2 copies (one for their own records and one for the daycare or Head Start facility) The LPHA or Facility associated with the parents refusal of blood lead testing should also send one copy to the child's Primary Care Physician and retain the original in the LPHA or Facility medical record for the child.

For questions about blood lead testing or lead poisoning please see www.health.mo.gov and click on "Lead Poisoning & Prevention" or phone the Department of Health and Senior Services, Bureau of Environmental Epidemiology at 573-751-6102.