

**Blood Lead Test Requisition**  
**Michigan Department of Community Health**  
**Bureau of Laboratories - Trace Metals Section**

**P.O. Box 30035 3350 North Martin Luther King Jr. Blvd. Lansing Michigan 48909**  
**Phone: 517-335-9490 Fax: 517-335-9776 Web: HTTP://www.Michigan.gov/mdchlab**

Date Received @ MDCH	Initials
MDCH Specimen Number	

Print in UPPERCASE using dark pen      Detailed instructions on reverse

**SUBMITTER INFORMATION**

SUBMITTER CLINIC CODE      AGENCY - COMPANY NAME

NUMBER      STREET      TELEPHONE

CITY      STATE      ZIP

PHYSICIAN/SUBMITTER (EMPLOYER IF APPLICABLE)      NATIONAL PROVIDER IDENTIFIER

PHYSICIAN/SUBMITTER PHONE (EMPLOYER IF APPLICABLE)

**PATIENT INFORMATION**

LAST NAME      FIRST NAME      M.I.

NUMBER      STREET      APARTMENT #

CITY      STATE      ZIP

PATIENT PHONE      PARENT - GUARDIAN NAME (LAST/FIRST)

HEALTH PLAN/OCCUPATION (If Applicable)

BIRTH DATE (MM-DD-YYYY)      GENDER

FEMALE       MALE

RACE      ETHNICITY (If Appropriate)

WHITE       BLACK OR AFRICAN AMERICAN       MULTIRACIAL       AMERICAN INDIAN OR ALASKAN NATIVE       ASIAN       NATIVE HAWAIIAN OR PACIFIC ISLANDER       UNKNOWN       HISPANIC       MIDDLE EASTERN OR ARABIC

**SPECIMEN INFORMATION**

TUBE / SUBMITTER ID      COLLECTION DATE (MM-DD-YY)      COLLECTION TIME (MILITARY)      SPECIMEN TYPE

CAPILLARY       FILTER PAPER       VENOUS

**PAYMENT INFORMATION**

PAYMENT ENCLOSED       BILL TO SUBMITTER       EXEMPT (MUST BE PRE-AUTHORIZED)       HEADSTART

MEDICAID #

**OPTIONAL - MAIL ADDITIONAL COPY TO**

ADDITIONAL CLINIC CODE      AGENCY - COMPANY NAME