

**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                |
| CITY                  | TELEPHONE             |
|                       | STATE      ZIP        |

**PATIENT INFORMATION**

|   |   |                                |
|---|---|--------------------------------|
| LAST NAME   | FIRST NAME  | M.I.                           |
| NUMBER  | STREET  | APARTMENT #                    |
| CITY  | STATE   | ZIP                            |
| PATIENT PHONE   |   |                                |
| BIRTH DATE (MM-DD-YYYY)   | GENDER  | PATIENT SOCIAL SECURITY NUMBER |
|   | <input type="radio"/> FEMALE <input type="radio"/> MALE   |                                |
| PHYSICIAN / EMPLOYER  | HEALTH PLAN / OCCUPATION  |                                |
| PHYSICIAN PHONE   |   |                                |
| RACE  | ETHNICITY (If Appropriate)  |                                |
| <input type="radio"/> WHITE <input type="radio"/> BLACK OR AFRICAN AMERICAN <input type="radio"/> MULTIRACIAL <input type="radio"/> AMERICAN INDIAN OR ALASKAN NATIVE <input type="radio"/> ASIAN <input type="radio"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER | <input type="radio"/> UNKNOWN <input type="radio"/> HISPANIC <input type="radio"/> MIDDLE EASTERN OR ARABIC |                                |
| PARENT - GUARDIAN NAME (LAST/FIRST)   | PARENT - GUARDIAN SOCIAL SECURITY NUMBER  |                                |

**SPECIMEN INFORMATION**

|                     |                            |                            |   |
|---------------------|----------------------------|----------------------------|---|
| TUBE / SUBMITTER ID | COLLECTION DATE (MM-DD-YY) | COLLECTION TIME (MILITARY) | SPECIMEN TYPE   |
|                     |                            |                            | <input type="radio"/> CAPILLARY <input type="radio"/> FILTER PAPER <input type="radio"/> VENOUS |

**PAYMENT INFORMATION**

|  |   |   |   |
|--|---|---|---|
| <input type="radio"/> PAYMENT ENCLOSED           | <input type="radio"/> GRANTS OR OTHER FUNDED PROGRAMS | <input type="radio"/> BILL TO PROVIDER (Quarterly Bill) | <input type="radio"/> EXEMPT (MUST BE PRE-AUTHORIZED) |
| <input type="radio"/> HEADSTART (Quarterly Bill) | <input type="radio"/> MEDICAID #                      |   |   |

**OPTIONAL - MAIL ADDITIONAL COPY TO**

|                        |                       |
|------------------------|-----------------------|
| ADDITIONAL CLINIC CODE | AGENCY - COMPANY NAME |
|                        |                       |