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C. State	
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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES MISSOURI STATE PUBLIC HEALTH LABORATORY **BLOOD LEAD** TEST REQUEST

Accession Number Barcode (For SPHL use only)

TEST REQUESTED												
SPECIMEN TYPE		DATE	COLLECTED	(YYYY/MM/DD)	SPEC	ECIMEN ID (SUBMITTERS SPECIMEN ID)						
Venous	Capillary											
PATIENT INFORMAT	ION (REQUIRED)											
PATIENT LAST NAME PATIENT FIRST NAME												
	1											
BIRTH DATE (YYYY/MM/DD)	ADDRESS											
			STATE	710 0005								
CITY		STATE		ZIP CODE	ZIP CODE		TELEPHONE NUMBER					
GENDER		RACE										
Female Male	9	W	/hite B	lack/African A	ck/African American		Asian American Indian/Alaskan Native					
ETHNICITY		- Native Hawaiian/Pacific			lander		Other Unknown					
Hispanic Non	Hispanic Unknown											
ORDERING CLINICIA	AN INFORMATION											
LAST NAME					FIRST	NAME						
CLINICIAN FACILITY NAME					1	FELEPH	ONE NUMBER					
ADDRESS				CITY					5	STATE	ZIP CODE	
SUBMITTER INFORM	MATION (RESULTS AR	ERETU	JRNED TO	D THIS ADD	RESS	5)						
NUMBER	NAME											
									1			
ADDRESS	CITY STATE ZIP CODE						ZIP CODE					
SUBMITTER CONTACT NAME SUBMITTER TELEPHONE NUMBER OUTREACH EVENT												
SUBMITTER CONTACT NAME SUBMITTER TE			I ELEPHONE NU	IMBER		OUTREACH E	EVENI					
ADDITIONAL PATIEN			JARDIAN FIRS									
PARENT/GUARDIAN LAST NAW	1	PARENT/G	JARDIAN FIRS			PARE	IN I/GUARDIAN	N DATTIME PHONE I	NUMBER			
REASON FOR LEAD SCREENIN		Fallow		mantama of l		loonin	or Othe	or				
Routine Screening Confirmatory Venous Follow-up Symptoms of Lead Poisoning Other												
Prenatal Screening	Occupational ===> Em	ployer's l	Name:									
BILLING INFORMATI	ON - Submitter will be b	illed \$16	6.50 per sa	ample. No f	ee will	be c	harged for	Medicaid clier	nts and	d LPH	As.	
PAYMENT SOURCE			M	EDICAID NUMBE	R/DCN							
Private Insurance	nce Personal Pay Medicaid											
Unknown	Unknown Unable to Pay*											
*PROVIDER SIGNATURE ATTESTING CLIENTS INABILITY TO PAY.												
MO 580-3135 (4-18)											LAB 13C1	

