



## LEAD SCREENING QUESTIONNAIRE

PATIENT'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ GENDER:  Male  Female

NAME OF GUARDIAN: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIPCODE: \_\_\_\_\_

COUNTY: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

NAME OF ORDERING PROVIDER: \_\_\_\_\_

### PLEASE INDICATE PATIENT'S RACE:

- White/Caucasian
- Black/African American
- Asian/Pacific Islander
- Native American/Alaskan
- Unknown
- Other Please Specify: \_\_\_\_\_

### DOES THE PATIENT HAVE HISPANIC HERITAGE?

- Yes
- No
- Unknown

### WHAT IS THE PURPOSE OF THIS TESTING?

- Initial (First Time)
- Follow-up Testing (Level on initial not within normal limits)
- Repeat (2 or more times tested)

### SPECIMEN COLLECTED BY:

- Venipuncture
- Fingertick