|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Department of Health Services**  Division of Public Health  F-00017 (02/2025) | | | | | | | | | **State of Wisconsin**  Bureau of Environmental & Occupational Health  Chapter DHS 181  608-266-5817 | | | | | | |
| **Blood Lead Lab Reporting** | | | | | | | | | | | | | | | |
| This form is authorized under sections 250.04(3) and 254.13, Wis. Stats. and Chapter DHS 181, Wis. Admin. Code. Health care providers and laboratories are required to report all blood lead test results and all other information shown on this form if they obtain or analyze blood to determine lead in blood. Failure to report all this information within the required time limits is subject to forfeiture of up to $5,000 per day of violation. The Department of Health Services will keep personally identifiable information about the patient confidential and will use these data only for legally authorized purposes. | | | | | | | | | | | | | | | |
| Patient’s Last Name | | | | | | | | | First Name | | | | | | Middle Initial |
|  | | | | | | | | |  | | | | | |  |
| Date of Birth (mm/dd/yyyy) | | | Sex | | | | | | Ethnicity (Check Appropriate Box) | | | | | | |
|  | | | Male  Female | | | | | | Hispanic or Latino  Not Hispanic or Latino  Unknown | | | | | | |
| Race (Mark all that apply) | | | | | | | | | | | | | | | |
| American Indian or Alaska Native | | | | Asian | | | | Black or African American | | | | | Native Hawaiian or Other Pacific Islander | | |
| White | Unknown  Other, specify: | | | | | | | | | | | | | | |
| Patient’s Street Address | | | | | | | | | | | | | | | Apartment Number |
|  | | | | | | | | | | | | | | |  |
| City | | | | | | | County | | | | | | | State | ZIP Code |
|  | | | | | | |  | | | | | | |  |  |
| Parent/Guardian (Last, First, Middle Initial) (If Patient is Under 18 Years of Age) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Phone Number of Patient or Parent/Guardian (If Patient is Under 18 Years of Age) | | | | | | | | | | | | | | | |
| Home:    -   - | | | | | | | | | Work:    -   - | | | | | | |
| Patient’s Employer Name (If Patient is 16 Years of Age or Older) | | | | | | | | | | | | Occupation | | | |
|  | | | | | | | | | | | |  | | | |
| Employer’s Address (Street, City, State, ZIP Code) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Name of Health Care Provider | | | | | | | | | | | | | | | Phone Number |
|  | | | | | | | | | | | | | | | -   - |
| Address of Provider (Street, City, State, ZIP Code) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Name of Physician (If Different than Health Care Provider) | | | | | | | | | | | | | | | Phone Number |
|  | | | | | | | | | | | | | | | -   - |
| Address of Physician (Street, City, State, ZIP Code) | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Date Blood Collected (mm/dd/yyyy) | | | | | Blood Collection Type (Check One) | | | | | | | | | | |
|  | | | | | Venous | | | | | | Capillary | | | | |
| **Additional Information to Be Provided by the Laboratory** | | | | | | | | | | | | | | | |
| Laboratory Name | | | | | | | | | | | | Clinical Laboratory Improvement Amendment Number | | | |
|  | | | | | | | | | | | |  | | | |
| Address (Street, City, State, ZIP Code) | | | | | | | | | | | | | | | Phone Number |
|  | | | | | | | | | | | | | | | -   - |
| Date of Analysis (mm/dd/yyyy) | | | | **Blood Lead Test Result:** **micrograms lead per deciliter** **of blood** | | | | | | | | | | | |
|  | | | |
|  | | | | | | | | | | | | | | | |
| **Timetable for Reporting** | | | | | |  | | | | **Submit to:** | | | | | | |
| Blood Lead Result (micrograms/deciliter) | | Report Within | | | |  | | | | Wisconsin Department of Health Services | | | | | | |
|  | | | | Division of Public Health | | | | | | |
| 45 or more | | 24 hours | | | |  | | | | 1 W Wilson Street, Room 145 | | | | | | |
| 3.5 – 44 | | 48 hours | | | |  | | | | Madison, WI 53703-2659 | | | | | | |
| 0 – less than 3.5 | | 10 days | | | |  | | | | **Fax No.: 608-267-0402** | | | | | | |
| For more information on adult blood lead test reporting visit <https://www.dhs.wisconsin.gov/adult-lead/labs-researchers.htm>, and for childhood blood lead test reporting visit <https://www.dhs.wisconsin.gov/lead/test-your-child.htm>  For information about electronic reporting, or other questions, email [dhsleadpoisoningprevention@wi.gov.](mailto:dhsleadpoisoningprevention@dhs.wisconsin.gov) | | | | | | | | | | | | | | | | |