State of Illinois
Department of Public Health

Report of Blood Lead Test Result

Illinois Lead Program
525 West Jefferson Street, Third Floor
Springfield, Illinois 62761-0001
Phone: 217-782-3517 Fax: 217-557-1188
TTY (hearing impaired use only) 800-547-0466

Child's Name Last _____ First _____ Middle Init ____

Parent/Guardian's Name Last _____ First _____

Phone _____ Date of Birth _____

Child's Address _____ County _____

City _____ State ____ ZIP Code _____

Medicaid Number _____ Sex (check appropriate one) ◯ Male ◯ Female ◯ Unknown

Race (check appropriate box)
☐ White ☐ Asian ☐ Other _____
☐ Black ☐ American Indian

Hispanic (check appropriate one)
◯ Yes
◯ No

Date of First Test _____

Type
◯ Venous ◯ Capillary

First Test Result _____ mcg/dL

Date of Second Test _____

Type
◯ Venous ◯ Capillary

Second Test Result _____ mcg/dL

Testing Facility (Laboratory) _____ Phone _____

(Physician/hospital laboratory submitting report)
Name _____ Phone _____

Clinic/Hospital _____

Address _____

City _____ State ____ ZIP Code _____

Signature of Person Completing Form _____ Date Reported _____

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