



Specimen# \_\_\_\_\_

**LEAD SCREENING QUESTIONNAIRE**

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

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

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

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

**TELEPHONE NUMBER:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_ (M) \_\_\_\_\_ (F) **COUNTY:** \_\_\_\_\_

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

**PLEASE INDICATE PATIENT'S RACE:**

- \_\_\_\_\_ White / Caucasian
- \_\_\_\_\_ Black / African American
- \_\_\_\_\_ American Indian
- \_\_\_\_\_ Asian
- \_\_\_\_\_ Other Please Specify \_\_\_\_\_

**DOES THE PATIENT HAVE HISPANIC HERITAGE?**

- \_\_\_\_\_ Yes
- \_\_\_\_\_ No

**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 \_\_\_\_\_

Fingerstick \_\_\_\_\_

PST \_\_\_\_\_