HEAVY METAL REPORTING FORM

Cuyahoga Co. Board of Health
5550 Venture Dr.
Parma, OH 44130
Fax: 216-676-1319

Cleveland Dept. of Public Health
75 Erieview Plaza
Cleveland, OH 44114
Fax: 216-664-3353

Patient

Social Security Number
- -

Patient Name (Last, First, MI)

Date of Birth (MM,DD,YYYY)
/ /

Patient Gender
Male Female

Race
White Multiracial
Black Other
Asian/Pacific Islander
Native American/Alsakan

Ethnicity
Hispanic
Non-Hispanic
Other

Address (Street Name, House #, Apt)

City | County | Zip Code

Medicaid Number (12 digits)

Medicaid Eligible Yes No Unknown

Parent Phone Contact No. | Parent Name (Last, First)

Medical Provider

Phone

Physician/Health care Provider Name (Last, First, Credential)

Address (Street Address)

Address (Hospital, Medical Office or Facility Name)

Address (City, State, Zip)

Lab Result

Result
µg/dL

Draw Date (MM,DD,YYYY)
/ /

Analyte
Arsenic
Lead Cadmuim Mercury

Specimen Type
Capillary Venous

Accession Number

Matrix
Blood Urine

Analyze Date (MM, DD,YYYY)
/ /

Medical Provider

Phone

Address (Street Address)

Address (Hospital, Medical Office or Facility Name)

Information on this form is <u>required</u> for collection by the patient's health care provider and reporting by the analytical lab in accordance with Ohio Administrative Code 3701-32-05.

Revised 4/4/12

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