New Vision Medical Laboratories
750 W High St.
Lima, OH 45801
419-226-9021

Lead Testing Form

PATIENT INFORMATION

Name: Last_____First _____MI__

Sex_____ Date of Birth_____

Patient MRN:_____

Address:_____

City: _____State: _____Zip_____

County: _____Phone: (____)_____-_____

Race: _____Ethnicity_____

Medicaid #: _____

Patient SSN: _____-_____-_____

If patient is a **CHILD**, Complete the following:

Parent or Guardian Name:

Last: _____ First: _____

If patient is an **ADULT**, complete the following:

Patient Occupation: _____

Employer name: _____

Employer Address: _____

_____

Employer Phone #: (_____) _____-_____

TEST ORDER INFORMATION

_____ Lead , Whole blood (ILEAD)

Sample and Test Information

The following MUST be provided:

Sample Collection: Date_____ Time _____

Sample Type: (check one) _____Capillary

_____Venous

_____Other

Purpose (check one):

_____Child screen

_____Clinical Suspicion

_____ Employee Screen

_____ Follow-up test

_____Repeat test

_____Other_____

ORDERING PHYSICIAN INFORMATION

The Physician name **MUST** be provided: Physician's name: Last _____First_____

Address: _____

_____

Phone #: (____) _____-_____

NPI #:_____