

REFERRAL TO:
ALAMEDA COUNTY LEAD POISONING PREVENTION PROGRAM
FAX COMPLETED FORM TO: (510) 567-8272

Referral Date: _____ Referred by: _____

PATIENT INFORMATION			
Last Name:	First Name:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address: Apt#:	City/Zip:	Primary Language:	
Phone: ()	Alternate Phone#: ()	Health Insurance:	

BLOOD LEAD TESTING INFORMATION							
DATE	BLOOD LEAD LEVEL (µg/dL)	Venous	Capillary	Hematocrit	Hemoglobin	Height	Weight
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
History of Anemia: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN				Currently On Iron Supplements: <input type="checkbox"/> YES <input type="checkbox"/> NO			

MEDICAL PROVIDER INFORMATION		
Last Name:	First Name:	Clinic:
Address:		
City:		
Phone: ()	Fax: ()	Email:

CARE GIVER INFORMATION				
	LAST NAME	FIRST NAME	PHONE	OCCUPATION
MOTHER				
FATHER				
OTHER				