ENVIRONMENTAL REFERRAL TO:

The NC Childhood Lead Poisoning Prevention Program

FAX COMPLETED FORM TO (919) 841-4015

Prenatal care providers should use this form to request a lead home investigation for a pregnant patient with two venous blood lead levels (≥ 5 µg/dL) within a 12-month period.

Referral Date: _____ Referred by: _____

PATIENT INFORMATION		
Last name:	First name:	DOB:
Street address: Apt.#:	City/Zip:	Language (check all that apply): ☐ English ☐ Other _____
Phone #:	Alternate phone #:	Medicaid # (if any):
BLOOD LEAD TEST INFORMATION: INITIAL TEST #1		
Date collected:	Blood Lead Level (µg/dL):	☐ Venous (only)
Analyzing laboratory name:	Laboratory address:	Phone #:
BLOOD LEAD TEST INFORMATION: DIAGNOSTIC/ CONFIRMATORY TEST #2		
Date collected:	Blood Lead Level (µg/dL):	☐ Venous (only)
Analyzing laboratory name:	Laboratory address:	Phone #:

Blood lead samples must be sent out for analysis to a reference laboratory that uses a high complexity method of analysis.

PRENATAL CARE PROVIDER INFORMATION		
Last name:	First name:	Clinic:
Address:		City/Zip code:
Phone #:	FAX #:	Email:

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