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

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)	

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)

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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