



# New Hampshire Division of Public Health Services Lead Care II Blood Lead Laboratory Reporting Form

Agency Name \_\_\_\_\_ CLIA# \_\_\_\_\_

Agency Address \_\_\_\_\_

Agency City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Agency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Client: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

DOB \_\_\_\_\_ (MM/DD/YY) Sex M  F  PT'S MEDICAL ID# \_\_\_\_\_

Client Street Address (No PO#) \_\_\_\_\_

Client City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Parent/Guardian Phone # \_\_\_\_\_

Employer (if over age 16) \_\_\_\_\_

Occupation (if over age 16) \_\_\_\_\_

Ethnicity Hispanic/Latino  Non-Hispanic/Non-Latino

Race  American Indian/Alaskan Native  Native Hawaiian/Other Pacific Islander  
 Asian  White  
 Black/African American  Multiracial

Refugee Y  N

Doctor's Name (Last name, First name) \_\_\_\_\_

Practice Name (No abbreviations) \_\_\_\_\_

Practice Address \_\_\_\_\_

Practice City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Practice Phone \_\_\_\_\_

Date of Specimen Collected \_\_\_\_\_ Date Specimen Analyzed: \_\_\_\_\_ Capillary

Results \_\_\_\_\_ mcg/dL (Do not write LOW)

Signature of person performing test \_\_\_\_\_

Printed Name of person performing test \_\_\_\_\_

## QUESTIONS:

Healthy Homes & Lead Poisoning Prevention Program  
29 Hazen Drive, Concord, NH 03301  
PH: (603) 271-4507 FAX: (603) 271-3991

### HOW QUICKLY DO I NEED TO REPORT THE RESULTS TO THE STATE?

45 mcg/dL or greater 1 business day

20 to <45 mcg/dL within 3 business days

10 to <19 mcg/dL within 10 business days