

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:	City/Zip:	Spoken Language (<i>check all that apply</i>) <input type="checkbox"/> English <input type="checkbox"/> Other: _____	
Apt#:			
Phone: ()	Alternate Phone#: ()	Health Insurance:	

BLOOD LEAD TESTING INFORMATION

Date	BLOOD LEAD LEVEL (µg/dL)		Hematocrit	Hemoglobin	Height	Weight
	Venous	Capillary				
	<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/Zip:	
Phone: ()	Fax: ()	Email:

CARE GIVER INFORMATION

	Last Name	First Name	Phone	Relationship to Child
Parent/Caregiver				
Parent/Caregiver				
Parent/Caregiver				

ALAMEDA COUNTY HEALTHY HOMES DEPARTMENT

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www.achhd.org

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