



LEAD DEMOGRAPHIC FORM

Please submit this form when ordering Lead Testing.
 This form must accompany a laboratory test requisition.

PLEASE PRINT CLEARLY

Patient	Full Name:	
	Street /PO Box	
	City	
	State	Zip Code
Guardian	Full Name:	
	Home Phone:	
Sample Check one	<input type="checkbox"/>	Venous
	<input type="checkbox"/>	Capillary
Date of Collection		
Race: Check one	<input type="checkbox"/>	White (Non-Hispanic)
	<input type="checkbox"/>	Black (Non-Hispanic)
	<input type="checkbox"/>	Hispanic
	<input type="checkbox"/>	Asian/Pacific Islander
	<input type="checkbox"/>	American Indian/Alaskan Native
	<input type="checkbox"/>	Other
Insurance:	<input type="checkbox"/>	Private Insurer
	<input type="checkbox"/>	Medicaid
	<input type="checkbox"/>	No insurance
	<input type="checkbox"/>	Unknown
Ordering Provider:	Full Name:	
	Practice Name:	
	Street /PO Box	
	City	Zip Code

Submit to: Fletcher Allen Health Care
 Pathology & Laboratory Medicine EP1-100
 111 Colchester Avenue
 Burlington VT 05401
 Phone: 847-5121 or 1-800-991-2799 Fax 1-802-847-6079