MISSISSIPPI STATE DEPARTMENT OF HEALTH

Report of Lead Levels

Last Name _____First Name _____ Medicaid # _____

DOB _____Sex _____ Race_____ Social Security # _____

Mailing Address _____ City _____

Zip Code _____County _____ Phone Number _____

Physical Address (**if different***) _____City _____

Zip Code _____ County _____

Parent/ Guardian Name _____

Lead Reports:
Date of Tests: _____ Lead Level _____ Venous _____ Capillary _____

Date of Tests: _____ Lead Level _____ Venous _____ Capillary _____

Date of Tests: _____ Lead Level _____ Venous _____ Capillary _____

Follow Up Care:
Next scheduled testing date: _____
WIC: Yes _____ No _____
Lead Poisoning Education Provided: Yes_____ No_____
Please list: _____
_____
_____

Clinic Information:
Name of Clinic _____
Address _____
Physician _____

Please print legibly in black ink.

MSLPPHHP Data: Crystal Veazey (601) 576-7447, Fax (601) 576-7498