Spectrum Health Regional Laboratories
Lead Screen Filter Paper Worksheet

http://spectrumhealth.testcatalog.org
Call Center Phone: 616-774-7721

SPECTRUM HEALTH

ID: _____ OFFICE NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

Date ordered	Date collected	Time collected	Collector

Patient Information - REQUIRED

Name Last First MI

Address Phone

City State Zip

Sex | Social Security No. | Birth Date | Cell Phone

Ethnicity (REQUIRED)
❍ Hispanic or Latino/Latina ❍ Not Hispanic or Latino/Latina

Race (REQUIRED)
❍ American Indian or Alaska Native ❍ Asian
❍ Black or African American
❍ Native Hawaiian or other Pacific Islander ❍ White or Caucasian

Provider Name: _____
PRINT First and Last Name. No Initials.
NPI:_____

Provider Signature: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION (fill in completely or attach a copy of patient's insurance card)

Name (Policy Holder) ❍ Self ❍ Spouse		SSN (Policy #)	Group #
Address	SSN	Recipient # (Medicaid)	Plan #
Insurance Company Name & Address	❍ PPOM ❍ HMO	Policy Holder's Employer Name & Address	

Parent or Guardian Information

Parent or Guardian Name (please print):	Phone number:	Parent Social Security No.:

Please fill out all of the information below

Physician orders:

LAB2111119 ❍ Lead Screen Filter Paper Diagnosis: _____

Specimen Collection Date _____ Time of Collection _____

Method of Collection (Check one) ❍ Capillary ❍ Venous

Any other pertinent information or comments:

Label specimen with 2 patient identifiers (name and date of birth)

SH LAB LEAD FORM (07/2018)