State of Illinois
Illinois Department of Public Health

Report of Blood Lead Test Result

For pregnant patients please use: Prenatal Form

Patient's Name _____ (Last) _____ (First) _____ (Middle Initial)

Sex (check appropriate box) ☐ Male ☐ Female Date of Birth _____

Parent/Guardian's Name _____ (Last) _____ (First) Phone _____

Patient's Address _____ Apt # _____ County _____

City _____ State _____ ZIP Code _____

Medicaid Number (if applicable) _____

Race (check all that apply) ***(The selection of at least one option is required)***

☐ White ☐ American Indian/Native Alaskan ☐ Asian

☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ Unknown

Hispanic or Latino

☐ Yes ☐ No

Date of Test _____ Type ☐ Venous ☐ Capillary Test Result ☐ Low <3.3 ☐ _____ mcg/dL ☐ High >65

Institution _____ Phone _____

Address _____

City _____ State _____ ZIP Code _____

Provider Name _____ (Last) _____ (First) _____ (Credentials) Phone _____

Testing Facility / Lab _____ Lab ID # _____ Phone _____

Printed Name (Person Completing Form) _____ Date Reported _____

Return to: Illinois Lead Program via
Secured Email: DPH.Lead@illinois.gov
Fax: 217-557-1188
525 West Jefferson Street, Third Floor
Springfield, Illinois 62761-0001
Phone: 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Timeframe for Reporting All Lead Results	
Blood Lead Result	**Report Within**
35.1 µg/dL or higher	24 hours
3.5 - 35 µg/dL	48 hours
0 - 3.4 µg/dL	30 days

Submit Completed Form to IDPH

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