



MISSISSIPPI STATE DEPARTMENT OF HEALTH

**Report of Lead Levels**  
Please print legibly in black ink.

**Child's Information**

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's Information**

Parent/Guardian Name \_\_\_\_\_ Secondary Phone Number \_\_\_\_\_

Parent's Occupation \_\_\_\_\_

Country of Origin \_\_\_\_\_

**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 \_\_\_\_\_

MSLPPHHP Data: Telephone (601) 576-7620, Fax (601) 576-7498