



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 _____

MSLPHP Data: Telephone (601) 576-7447, Fax (601) 576-7498 or (601) 576-7540