Blood Lead Level Report: Point-of-Care

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Instructions:

1. **Fax this from within 7 days to 402-471-3601, ATTN: Nebraska DHHS Lead Program.**
2. This report is only to be used for reporting capillary blood lead samples using point-of-care (POC) lead tests.

Reporting Facility Name: ______________________________ **Phone**: __________ **Report Date**: ________

Clinic/Facility Address: ______________________________________ **City**:__________ **Zip**: ______

Provider Name:__________________________ Test Site Location: ______________________________
(if different than reporting facility)

Codes for Race: **W** = White; **B** = Black or African American; **I** = American Indian or Alaskan Native; **A** = Asian; **P** = Native Hawaiian or Other Pacific Islander; **O** = Other

Child's First Name	**MI**	**Last Name**	**DOB**		**Sex**	**Race***	**Ethnicity***	Medicaid #
			MM/DD/YYYY		☐ M ☐ F		☐ Hisp ☐ Non-Hisp	
Address	**Apt#**	**City**	**Zip**	**ST**	Phone		**Date of Test**	**Result**
							MM/DD/YYYY	mcg/dL

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All items in **bold** are required. *Required if available. Report by fax or mail within 7 days. All blood lead level tests (negative and positive) are required to be reported by health care providers and laboratories pursuant to Nebraska reportable disease regulations (173 NAC 1).