



LABORATORY ALLIANCE

of Central New York, LLC

www.laboratoryalliance.com

Ph: (315) 461-3008 Fax: (315) 461-3090

PLACE BAR CODE LABEL HERE

VO BOX

Blood Lead Test Requisition

PATIENT INFORMATION

PATIENT NAME (LAST/FIRST/MI)		
COUNTY OF RESIDENCE	SOCIAL SECURITY NO.	
PHONE NO.	DATE OF BIRTH	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS		
CITY, STATE, ZIP		

INSURANCE BILLING INFORMATION

RESPONSIBLE PARTY (SUBSCRIBER)	
SUBSCRIBER SOCIAL SECURITY NO.	
PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____	
SUBSCRIBER'S ADDRESS (CITY/STATE/ZIP)	
PRIMARY INSURANCE: CO. NAME	
POLICY NO.	GROUP NO.
SECONDARY INSURANCE: CO. NAME	
POLICY NO.	GROUP NO.

TYPE OF SAMPLE	
<input type="checkbox"/> LEAD - VENOUS (LEADV)	<input type="checkbox"/> LEAD - CAPILLARY/FINGERSTICK (LEADCP)

SPECIMEN INFORMATION

DATE COLLECTED	TIME COLLECTED	COLLECTED BY
/ /	<input type="checkbox"/> AM <input type="checkbox"/> PM	
CLINICAL DIAGNOSIS / ICD9 DIAGNOSIS CODE		
PHYSICIAN'S SIGNATURE (REQUIRED FOR MEDICAID)		
COPY TO		

THE INFORMATION BELOW IS REQUIRED BY THE NEW YORK STATE DEPARTMENT OF HEALTH FOR FOLLOW-UP OF THIS LEAD TEST

PATIENT'S RACE:	
<input type="checkbox"/> AFRICAN AMERICAN (B) <input type="checkbox"/> CAUCASIAN (W) <input type="checkbox"/> NATIVE AMERICAN (I) <input type="checkbox"/> ASIAN (A) <input type="checkbox"/> HISPANIC (H) <input type="checkbox"/> OTHER (O) <input type="checkbox"/> UNKNOWN (U)	
IF PATIENT IS MINOR, PRINT PARENT OR GUARDIAN'S NAME (LAST, FIRST, MI)	PARENT OR GUARDIAN'S PHONE
	/ /

PATIENT AUTHORIZATION

I authorize the release to my insurance carrier of any medical information necessary to process this claim, and I authorize payment of medical benefits directly to Laboratory Alliance of Central New York, LLC.

Signature (Patient or person authorized to consent for patient)

X _____ DATE _____

PRINT PHYSICIAN NAME (Last) (First) (MI)	PHYSICIAN PHONE
	/ /
PHYSICIAN ADDRESS (STREET NUMBER, CITY, STATE, ZIP)	

FOR LABORATORY USE ONLY / LABORATORY PFI #7409

DATE OF ANALYSIS	TECH INITIALS
/ /	
TEST RESULTS	
_____ ug/dL	
COMMENTS	