REFERRAL TO:

Alameda County Lead Poisoning Prevention Program

FAX COMPLETED FORM TO: (510) 567-8272

Referral Date: _____ Referred by: _____

PATIENT INFORMATION

Last Name:	First Name:	DOB:	☐ Male ☐ Female
Address: Apt#:	City/Zip:	Spoken Language *(check all that apply)* ☐ English ☐ Other: _____	
Phone: ( )	Alternate Phone#: ( )	Health Insurance:	

BLOOD LEAD TESTING INFORMATION

Date	Blood Lead Level (µg/dL) Venous ☐ Capillary ☐	Hematocrit	Hemoglobin	Height	Weight
History of Anemia: ☐ Yes ☐ No ☐ Unknown		Currently On Iron Supplements: ☐ Yes ☐ No			

MEDICAL PROVIDER INFORMATION

Last Name:	First Name:	Clinic:
Address:		City/Zip:
Phone: ( )	Fax: ( )	Email:

CARE GIVER INFORMATION

	Last Name	First Name	Phone	Relationship to Child
Parent/Caregiver				
Parent/Caregiver				
Parent/Caregiver				

ALAMEDA COUNTY HEALTHY HOMES DEPARTMENT

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www.achhd.org

Updated May 2014