SPECIALTY LABORATORIES
27027 Tourney Road 800•421•7110
Valencia, CA 91355 www.specialtylabs.com

Heavy Metal (Lead) Supplemental Patient Information Form

PLEASE PRINT

PATIENT NAME (Last) (First) (MI)			
PATIENT STREET ADDRESS			APT #
CITY	COUNTY	STATE	ZIP CODE
DATE OF BIRTH	AGE	GENDER ☐ MALE ☐ FEMALE	PATIENT SOC SEC #
RACE (Check appropriate box) ☐ ASIAN ☐ BLACK ☐ NATIVE AMERICAN ☐ WHITE ☐ MULTI-RACE ☐ OTHER ☐ UNKNOWN		ETHNICITY (Check appropriate box) ☐ HISPANIC/LATINO ☐ NON-HISPANIC/NON-LATINO ☐ UNKNOWN	
GUARDIAN NAME (If patient is under 18 years of age)		PATIENT/GUARDIAN PHONE NUMBER	
PATIENT'S EMPLOYER NAME (If patient is 16 years of age or older)	OCCUPATION	PATIENT'S SCHOOL NAME (If patient is under 18 years of age)	
SUBSCRIBER NAME		SUBSCRIBER/MEDICARE/MEDICAID #	
TYPE OF SAMPLE SUBMITTED ☐ VENOUS ☐ CAPILLARY		DRAW DATE	

The information is required for State Public Health follow-up of heavy metal testing. Please provide complete patient demographic information as required by your State Department of Health at the time of test order. For more information, call Support Systems 800-421-7110, ext. 6770 or FAX 661-799-5281.

NAME OF HEALTH CARE PROVIDER	PHONE NUMBER
PROVIDER ADDRESS (Street, City, State, Zip Code)	
NAME OF PHYSICIAN (If different than Health Care Provider)	PHONE NUMBER
PHYSICIAN ADDRESS (Street, City, State, Zip Code)	
PURPOSE OF TEST ☐ INITIAL ☐ REPEAT ☐ FOLLOW UP	SPECIALTY LABORATORIES PFI# 3197-805183AO

Name of Person Completing Form (please print) _____