

Vermont Department of Health Laboratory – Blood Lead Test Requisition

Mailing Address: PO Box 1125, Burlington, VT 05402-1125
 Physical Address: 359 South Park Drive, Colchester VT 05446 • (802) 338-4724 / (800) 660-9997 in VT only

By using this form the submitter is requesting a blood lead test order to be placed at the Vermont Department of Health Laboratory.

All specimens must be labeled with matching patient name, date of birth and date of collection.

For Laboratory Use Only				
VDH Lab Number/LIMS #			<input type="checkbox"/> Mis-matching Information between specimen and requisition <input type="checkbox"/> Missing information on specimen: <u> </u> FN <u> </u> LN <u> </u> DOC <u> </u> DOB <input type="checkbox"/> Missing purple end cap <input type="checkbox"/> No outer sleeve on capillary tube <input type="checkbox"/> No biohazard bag	
Submitter/Practice Information			Patient Information	
Practice Name Or VDH District Office			Last Name	MI
			First Name	
Address	State	Zip Code	Date of Birth (mm/dd/yyyy)	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
City/Town	Extension		Street Address Apt # or Unit #	
Telephone Number			City/Town	
Contact Person or Lead Designee			State	Zip Code
Primary Care Practice (for District Office purposes)			Race (check one): <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Other <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> NOT Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Referring Physician (Last Name/First Name) Include credentials (MD, PA, etc.)			Parent/Guardian Name (Last Name/First Name) And Contact Phone #	
NPI #			Occupation (if patient is ≥ 16 years old)	Name of Employer (if applicable)
Specimen Information			Helpful Collection Tips	
Source <input type="checkbox"/> Blood Capillary <input type="checkbox"/> Blood Venous Date of Collection (mm/dd/yyyy) ICD-10 Code:			Collection instructions: https://www.healthvermont.gov/lab/forms Education materials and clinical consultation: www.healthvermont.gov/lead	Samples with insufficient volume will be rejected. 
Billing Information		<input type="checkbox"/> See Attached Sheet	<input type="checkbox"/> Check if No Insurance	
Subscriber Name		Medicaid Number		
Insurance Company Name		ID Number	Group Number	
Secondary Insurance Company Name		ID Number	Group Number	

Vermont Department of Health Laboratory – Blood Lead Test Requisition Form Instructions

Carefully read the following instructions. Using black or blue ink, complete the form in a clear and legible manner in the space provided. If additional space or information is necessary, submit additional pages with this form. The electronic form is a fillable document for typed entries.

Billing information may also be attached as a separate form; check box in Billing section “See Attached Sheet”.

Submitter Section:

1. You must enter **Name, Address** and **Telephone Number** of the Practice or District Office and the **Referring Physician**.
2. Enter the Contact person or Lead designee and Phone for the individual(s) responsible for receiving elevated results.
3. Enter the Primary Care practice if the Submitter is NOT the Primary Care Practice.

Patient Information Section:

1. The following fields must be entered: **Last Name, First Name**, and **Date of Birth**. This information must **exactly** match the specimen label.
2. Select **Gender**, Race and Ethnicity
3. Enter **Street Address, City, State and Zip Code**.
4. Enter Name of Parent/Guardian and phone number if patient is a minor.

Specimen Information Section:

1. You must select the applicable **source** for the specimen.
2. Enter the **Date of Collection**.
3. Enter the appropriate **ICD-10** code.

Billing Information Section:

1. Provide insurance information or check “No Insurance”.
2. Insurance information may be included on an attached sheet.

Shipping Guidelines:

- Specimens must be inside a small biohazard labeled recloseable bag in order to follow Universal Precautions.
- Specimens can be shipped through the mail using VDHL mailing tubes or delivered using a medical courier. VDHL is on the daily NECLA courier route.

Capillary tubes, venous tubes, biohazard labeled recloseable bags, instruction sheets, postage paid mailing tubes and requisition forms can all be ordered from the laboratory, **free of charge**, by calling Kit Preparation at (802) 338-4736 or use the order form. The order form can be mailed back to the Laboratory or faxed to (802) 338-4706.

All forms are available at the website www.healthvermont.gov/lab/forms

Under Forms and Ordering, the following forms are located:

- ✓ Blood Lead Test Requisition Form
- ✓ Blood Lead Specimen Collection Instructions
- ✓ Blood Lead Supplies Order Form

All fields are required to be filled out for VT/NH legal requirements for Reporting Blood Lead, CLIA certification requirements and VDH billing information.

Contact the Healthy Homes Lead Poisoning Prevention Program for lead education materials and clinical consultation or go to www.healthvermont.gov/lead