



COUNTY OF HUMBOLDT
 DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH LABORATORY
 PEPPER STOCKTON, LABORATORY DIRECTOR
 CLIA 05D0666113, MEDICARE/ MEDI-CAL ID # LAB58595F
 529 I ST., EUREKA CA 95501
 PHONE (707) 268-2179 Fax (707) 445-7640

INFORMATION MUST BE PROVIDED TO PROCESS TESTING - PLEASE PRINT CLEARLY

PATIENT'S LAST NAME			FIRST	MI	NAME/ADDRESS/PHONE OF SUBMITTING AGENCY, <i>if using a Stamp or Sticker please stamp in triplicate</i>	
ETHNICITY: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown						
RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Multiple Race						
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White <input type="checkbox"/> Black/African American						
GENDER	DOB	CHART#	SOCIAL SECURITY#			
RESPONSIBLE PARTY			PATIENT PHONE #			
PATIENT ADDRESS						
CITY/STATE/ZIP					NAME OF PHYSICIAN	

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the County of Humboldt Public Health Laboratory. I am financially responsible for any non-covered services. I also authorize the County of Humboldt Public Health Laboratory to process this claim.

SIGNED **DATE**
 If this is a confidential test and any balance not covered by insurance cannot be billed to your home, INITIAL HERE.

DIAGNOSIS/ICD10 CODE/ S CODE:

MEDI-CAL/CHDP # with AID CODE and COUNTY CODE (*write legibly*):

BILL OUR ACCOUNT INSURANCE (MUST INCLUDE COPY OF CARD)

PROOF OF ELIGIBILITY REQUIRED OR ACCOUNT WILL BE BILLED. ATTACH PHOTOCOPY OR COMPUTER PRINT-OUT TO BACK OF FORM.

Blood Lead Level Test Request: Capillary Blood only

DATE & TIME COLLECTED	COLLECTED BY
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STORAGE REQUIREMENTS:

- DO NOT FREEZE
- STORED AT ROOM TEMP UP TO 48 HOURS
- STORAGE IN THE REFRIGERATOR UP TO 6 DAYS

Below, for Lab Use only:

DATE & TIME RECEIVED	LAB CLIENT NUMBER:
COMMENTS/ OTHER:	LAB SPECIMEN NUMBER: