TO BE COMPLETED BY PATIENT

REPORT OF BLOOD-LEAD TEST

The Washington State Adult Blood Lead Epidemiology and Surveillance (ABLES) program is maintained to prevent lead exposure and its health effects among adults.

**** * * All information in the registry is strictly confidential * * ****

To the patient: Please complete this form now and return it to your doctor. If you find reading or writing difficult, ask someone for help. The information that you provide us will help us to prevent lead poisoning in Washington State workplaces. ***We will not release this information to anyone without your permission.***

YOUR NAME
First Middle Initial Last

HOME PHONE
( ) -

HOME ADDRESS
Street City State Zip County

DATE OF BIRTH (M/D/Y)
/ /

GENDER
❑ Male ❑ Female

WHAT IS YOUR OCCUPATION?

- ❑ Radiator Repairer
- ❑ Sand Blaster
- ❑ Welder
- ❑ Painter
- ❑ Glass
- ❑ Glazier
- ❑ Grinding
- ❑ Battery
- ❑ Builder
- ❑ Checker
- ❑ Other (state below)

_____

WHAT TYPE OF BUSINESS OR INDUSTRY DO YOU WORK IN?

- ❑ Auto Repair and Services
- ❑ General/Heavy Construction
- ❑ Battery Manufacturing
- ❑ Glass Products Manufacturing
- ❑ Chemical Manufacturing
- ❑ Other (state below)

_____

PLEASE CHECK ANY ACTIVITIES/ HOBBIES YOU HAVE PARTICIPATED IN DURING THE LAST SIX MONTHS

- ❑ Firing Range/Making Bullets
- ❑ Making Fishing Weights
- ❑ House Remodeling
- ❑ Pottery
- ❑ Stained Glass

COMPANY NAME / TELEPHONE
Name Phone ( ) -

COMPANY LOCATION (City)

PLEASE DESCRIBE THE MAIN TASKS YOU PERFORM AT YOUR JOB

1. Are you a supervisor? ❑ Yes ❑ No
2. Did your employer ask you to get this blood test? ❑ Yes ❑ No
3. Are any children under 6 living in your household? ❑ Yes ❑ No
4. Is any household member pregnant or nursing? ❑ Yes ❑ No

Are you of Hispanic origin? ❑Yes ❑No

What race are you?

- ❑ American Indian, Alaskan Native
- ❑ Asian
- ❑ Black
- ❑ White
- ❑ Native Hawaiian or other Pacific Islander race
- ❑ Other

Thank you for your assistance. If you have any questions or comments, or if you would like more information on occupational lead exposure, please call our **toll-free line at (888) 667-4277**.

Please fax (preferred) this completed form to: **360-902-5672**

Or mail to: **Adult Blood Lead Epidemiology and Surveillance (ABLES)**
PO Box 44330
Olympia WA 98504-4330

TO BE COMPLETED BY HEALTHCARE PROVIDER

**** * * All information in the registry is strictly confidential * * ****

To the provider: Please complete the portion below and ask your patient to complete the portion above. Promptly mailing this form will help our efforts to prevent occupational overexposure. It will also help us to avoid phone follow-up at a later date, which may be disruptive to you and your staff.

DATE (MM/DD/YYYY)
/ /

PHYSICIAN NAME
First Last

TELEPHONE
( ) -

CLINIC/DOCTOR'S OFFICE

ADDRESS