****NOT AN ORDERING FORM****
This form is only used to document additional demographics for Public Health Reporting for any reportable test.

Patient Demographics Form for Public Health Reporting

Your State or Local Health Department requires testing laboratories to report designated demographic information. Provide this information electronically via an interface or through the use of this form. Failure to provide the required information may result in a follow-up call from your State or Local Health Department.

Client Information (required)

Client Name	Client ID

Patient Information (required)

Patient Name *(Last, First, Middle)*			Patient ID (MRN or other ID#)	Specimen Collection Date
Sex	Date of Birth	Race	Ethnicity	Patient Phone ( ) –

Patient Address	City	County	State	Zip Code

Physician Information (required)

Physician Name *(Last, First)*	Physician Phone ( ) –

Physician Address	City	State	Zip Code

If the patient is a CHILD, please provide the following:

Parent/ Guardian Name *(Last, First)*

If the patient is an ADULT, and the testing is for lead/heavy metals or cholinesterase, please provide the following:

Patient's Occupation	Patient's Employer Name	Patient's Employer Phone ( ) –

Patient's Employer Address	City	State	Zip Code