Health care providers may use this form for making Heavy Metal reports. This includes heavy metals such as arsenic, cadmium, cobalt, lead, and mercury. Forms may be found at http://dhss.alaska.gov/dph/Epi/Pages/pubs/conditions/crforms.aspx.

### Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of birth ___/___/____ (mm/dd/yyyy)

Sex:  
- [ ] Female
- [ ] Male
- [ ] Transgender

Pregnant:  
- [ ] No
- [ ] Yes; # of weeks ________
- [ ] Unknown

Race:  
- [ ] White
- [ ] Black
- [ ] Alaska Native/American Indian
- [ ] Native Hawaiian/Pacific Islander
- [ ] Asian
- [ ] Unknown
- [ ] Other __________

Ethnicity:  
- [ ] Hispanic
- [ ] Non-Hispanic
- [ ] Unknown

- [ ] Transgender

Physical Address _____________________________________________ PO Box ______________

City ____________________________________________ State ______ Zip Code ___________

Phones (home) ___________________ (cell) ___________________ (work) ________________

### Heavy Metal and Toxic Exposure Information

<table>
<thead>
<tr>
<th>METAL</th>
<th>SPECIMEN</th>
<th>SPECIMEN COLLECTION DATE</th>
<th>TEST RESULT</th>
<th>NOTE SPECIES IF APPLICABLE (e.g. organic/inorganic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARSENIC</td>
<td>Urine □ Blood □ Serum □ Other Specimen: __________</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CADMIUM</td>
<td>Urine □ Blood □ Serum □ Other Specimen: __________</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COBALT</td>
<td>Urine □ Blood □ Serum □ Other Specimen: __________</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEAD</td>
<td>Urine □ Blood (capillary) □ Serum □ Blood (venous) □ Other Specimen:</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MERCURY</td>
<td>Urine □ Blood □ Serum □ Other Specimen: __________</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td>Urine □ Blood □ Serum □ Other Specimen: __________</td>
<td><strong>/</strong>/____</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient hospitalization time if applicable: ___________________ Name of Medical Facility ___________________

Attending health care provider ___________________ Phone ___________________

Laboratory Name (if known) ___________________

Notes (e.g., symptoms or suspected exposure source): Toxic symptoms if applicable:

Fax reports to (907) 561-4239 – please verify fax has been transmitted. 6/20/2018