

Confidential Heavy Metal and Toxic Exposure Report Form

State of Alaska, Section of Epidemiology



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

Last Name _____ First Name _____ MI _____

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

Physical Address _____ PO Box _____
 City _____ State _____ Zip Code _____
 Phones (home) _____ (cell) _____ (work) _____

Heavy Metal and Toxic Exposure Information

METAL	SPECIMEN	SPECIMEN COLLECTION DATE	TEST RESULT	NOTE SPECIES IF APPLICABLE (e.g. organic/inorganic)
<input type="checkbox"/> ARSENIC	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		
<input type="checkbox"/> CADMIUM	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		
<input type="checkbox"/> COBALT	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		
<input type="checkbox"/> LEAD	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		
<input type="checkbox"/> MERCURY	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		
<input type="checkbox"/> OTHER	<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other Specimen: _____	____/____/____		

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: