Accredited Environmental Technologies, Inc.

EBL/EBI Investigation Referral Form Date: _____

Child/Children Elevated Blood Level Information:

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child's Name: _____ Child's DOB_____ (M/F)

All Reported EBL Levels/Date_____

Child/Children's Primary Address:_____

City/State:_____ Apt/Unit #:_____

Child's Secondary Address (if applicable): _____

Apartment or Single Family Home (circle one) _____# of Bedrooms _____# of Floors

Parent/Guardian Information:

Parent/Guardian Name: _____ DOB:_____

Address (if different than Child's): _____Phone #: _____

Insurance Information: ***(Only required for 1 child if living in the same household. Please be sure to indicate which child information is for)***

Insurance Provider: _____

MA #/ID #: _____ Rx#/Auth#_____

Primary Care Physician (PCP) Information:

PCP Name: _____

Phone No.: _____ Fax No.: _____ Email Address: _____

Mailing Address: _____

**If PCP would like the final report mailed please provide mailing address otherwise AET will fax a copy once completed.*

Comments:_____

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