

# 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 \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Child's DOB \_\_\_\_\_ (M/F)

All Reported EBL Levels/Date \_\_\_\_\_

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Child's Name: \_\_\_\_\_ Child's DOB \_\_\_\_\_ (M/F)

All Reported EBL Levels/Date \_\_\_\_\_

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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:** \_\_\_\_\_  
\_\_\_\_\_