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: