

***INTERGOVERNMENTAL LEAD HAZARD REDUCTION PROGRAM
REFERRAL FORM TO OUTSIDE AGENCIES***

Date of Referral: _____

Referring Agency: St. Clair County Intergovernmental Grants Department _____
CDBG Operations Corporation _____

Client's Name: _____

Date of Birth: _____ Age of child: _____

Parent or Legal Guardian: _____

Address: _____

City / State / Zip: _____

Telephone Number: _____

Reason for Referral: (Circle one) 1. Client is applying for the Lead Hazard Reduction Program
2. Other _____

Please call and make an appointment at one of the following Health agencies.

St. Clair County Health Dept.
19 Public Square, Suite 150
Belleville, Illinois 62220
(618)233-6170
Ext. 4468 or 4466

East Side Health District
650 North 20th Street
East St. Louis, Illinois 62205
(618)874-4713

St. Mary's Hospital
129 North Eighth Street
East St. Louis, Illinois 62201
(618) 274-1900

Agency performing Lead Testing: _____

Date of Lead Test: _____ Results of Lead Test: _____

Form completed by: _____ Phone extension: _____

I am legally authorized to release the results of this lead test. I would like the results of this lead test released to the St. Clair County Intergovernmental Grants Department, for the purpose of completing my lead hazard reduction application.

Client / Parent / Legal guardian Signature

Date

