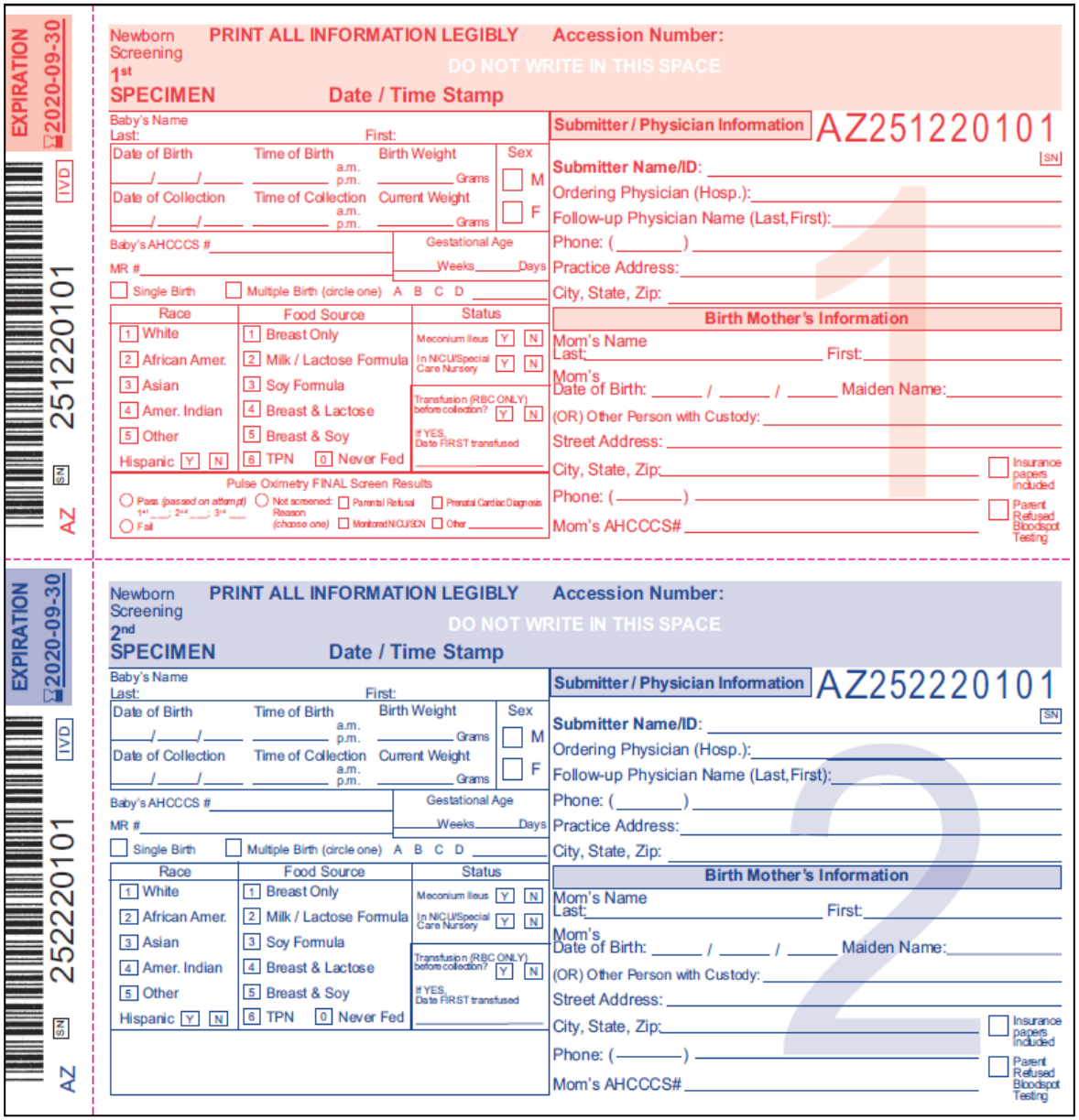
Linked Kit Sample- January 2018



EXPIRATION 2020-09-30

IVD

AZ SN 251220101

Newborn Screening 1st SPECIMEN

PRINT ALL INFORMATION LEGIBLY

Accession Number:

DO NOT WRITE IN THIS SPACE

Date / Time Stamp

Baby's Name
Last: First:

Date of Birth ____/____/____ Time of Birth _____ a.m. p.m. Birth Weight _____ Grams Sex M F

Date of Collection ____/____/____ Time of Collection _____ a.m. p.m. Current Weight _____ Grams

Baby's AHCCCS # _____

MR # _____

Gestational Age _____ Weeks _____ Days

Single Birth Multiple Birth (circle one) A B C D _____

Race	Food Source	Status
1 White	1 Breast Only	Meconium Ileus Y N
2 African Amer.	2 Milk / Lactose Formula	In NICU/Special Care Nursery Y N
3 Asian	3 Soy Formula	
4 Amer. Indian	4 Breast & Lactose	Transfusion (RBC ONLY) before collection? Y N
5 Other	5 Breast & Soy	If YES, Date FIRST transfused _____
Hispanic Y N	6 TPN 0 Never Fed	

Pulse Oximetry FINAL Screen Results

Pass (passed on attempt) 1st ____; 2nd ____; 3rd ____

Fail

Not screened: Reason (choose one) Parental Refusal Prenatal Cardiac Diagnosis Monitored NICU/SCN Other _____

Submitter / Physician Information AZ251220101

SN

Submitter Name/ID: _____

Ordering Physician (Hosp.): _____

Follow-up Physician Name (Last,First): _____

Phone: (_____) _____

Practice Address: _____

City, State, Zip: _____

Birth Mother's Information

Mom's Name Last: _____ First: _____

Mom's Date of Birth: ____/____/____ Maiden Name: _____

(OR) Other Person with Custody: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____

Mom's AHCCCS# _____

Insurance papers included

Parent Refused Bloodspot Testing

1

EXPIRATION 2020-09-30

IVD

AZ SN 252220101

Newborn Screening 2nd SPECIMEN

PRINT ALL INFORMATION LEGIBLY

Accession Number:

DO NOT WRITE IN THIS SPACE

Date / Time Stamp

Baby's Name
Last: First:

Date of Birth ____/____/____ Time of Birth _____ a.m. p.m. Birth Weight _____ Grams Sex M F

Date of Collection ____/____/____ Time of Collection _____ a.m. p.m. Current Weight _____ Grams

Baby's AHCCCS # _____

MR # _____

Gestational Age _____ Weeks _____ Days

Single Birth Multiple Birth (circle one) A B C D _____

Race	Food Source	Status
1 White	1 Breast Only	Meconium Ileus Y N
2 African Amer.	2 Milk / Lactose Formula	In NICU/Special Care Nursery Y N
3 Asian	3 Soy Formula	
4 Amer. Indian	4 Breast & Lactose	Transfusion (RBC ONLY) before collection? Y N
5 Other	5 Breast & Soy	If YES, Date FIRST transfused _____
Hispanic Y N	6 TPN 0 Never Fed	

Submitter / Physician Information AZ252220101

SN

Submitter Name/ID: _____

Ordering Physician (Hosp.): _____

Follow-up Physician Name (Last,First): _____

Phone: (_____) _____

Practice Address: _____

City, State, Zip: _____

Birth Mother's Information

Mom's Name Last: _____ First: _____

Mom's Date of Birth: ____/____/____ Maiden Name: _____

(OR) Other Person with Custody: _____

Street Address: _____

City, State, Zip: _____

Phone: (_____) _____

Mom's AHCCCS# _____

Insurance papers included

Parent Refused Bloodspot Testing

2