

1. Write the newborn's last name

Select appropriate box for initial testing or repeat testing on this newborn

Write the time of birth in military time HH:MM

4. Write the newborn's birth weight in grams.

2. Write the date of birth in MM/DD/YY

3. Write the date of collection in MM/DD/YY

Write the time of collection in military time HH:MM

5. Write the mother's last name, first name, address, her date of birth, and phone number. Select her race and ethnicity by checking the appropriate boxes.

6. Check the box next to your facility name, or write it here if it is not listed

Select male or female

Check this box if this was a multiple birth, and write birth order for newborn

7. Write your facility's neonatal ID # and street address

8. Write the newborn's primary care physician, zip code, NPI, and phone number

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENTAL LABORATORIES

KHEL USE ONLY

FOR NEONATAL SCREENING ONLY
FORM KS #740
COMPLIANT WITH CLS STANDARDS

REF: 10534623 REV: 01/14
X000000X
LOT: W000X

SN

10534623 REV: 01/14
X000000X
LOT: W000X

Select One
 INITIAL REPEAT

NEWBORN INFORMATION (BELOW)

LAST NAME: _____ FIRST NAME: _____

BIRTH DATE: MM/DD/YY _____ BIRTH TIME (MILITARY): HHMM _____ BIRTH WT IN GRAMS: _____

COLLECTION DATE: MM/DD/YY _____ COLLECTION TIME (MILITARY): HHMM _____ COLLECTION WT IN GRAMS: _____

INFANT IN NICU: YES NO
MEDICAL RECORD NUMBER: _____ SEX: M F

COLLECTED <24 HRS: YES NO
INFANT ON TPN: YES NO
TRANSFUSED: YES NO
DATE TRANSFUSED: MM/DD/YY _____

MULTIPLE BIRTH: YES NO
BIRTH ORDER: _____

MOTHER INFORMATION (BELOW)

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ STATE: _____ ZIP CODE: _____ DOB: MM/DD/YY _____

MOTHER'S RACE: WHITE BLACK AMERICAN INDIAN / ALASKAN NATIVE ASIAN / PACIFIC ISLANDER MULTIRACIAL UNKNOWN OTHER _____

ETHNICITY: HISPANIC / LATINO NON-HISPANIC
PHONE #: _____

SUBMITTER INFORMATION (BELOW)

NAME OF SUBMITTING FACILITY IF NAME NOT MARKED BELOW: _____ NEONATAL ID #: _____ STREET ADDRESS: _____

CHECK BOX NEXT TO NAME: WESLEY KUMC STORMONT SHAWNEE MISSION
 OPRMC IACH ST. JOSEPH ST. FRANCIS HOSP

COLLECTOR: _____

NEWBORN PRIMARY CARE PHYSICIAN

LAST NAME, FIRST NAME: _____

ZIP CODE: _____ PROVIDER NPI: _____

PHONE #: _____

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