

Form Name	Pennsylvania NBS
Design ID	PANB20171204034
Version	034
Design Date	12/04/17 CS

Dotted Magenta lines signify perf lines.

Sub: 7/16"

Folded Flap: 1 9/16"

All measurements can vary +/- 1/16" (1.6mm). Manufacturing equivalent substitutions allowed for demographic papers. Glue lines are between the stubs of parts 1, 2, 3, 4, and 6, and in between parts 5 and 6

Front of Form (Flap Folded)

PENNSYLVANIA DEPT. OF HEALTH
IVD
EXPIRES 2020-12-31

Pennsylvania Department of Health **TOP COPY FOR LAB; SUBMITTER MAY KEEP YELLOW COPY** **SN PA170145201**

Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514 Monitor for _____

<input type="checkbox"/> Initial Specimen	<input type="checkbox"/> Repeat Specimen - Initial FP#:	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Birth Facility Name ("Home" if home birth)	Code	<input type="checkbox"/> Single Birth	<input type="checkbox"/> Multiple Birth -> If Multiple <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other
Submitter Name	Code	Birth Date: / /	Time (Military)
Address if no CODE given		Current Wt.: _____	gms. <input type="checkbox"/> lbs.oz.
BABY'S Name (Last)	BABY'S Name (First)	Collection Date	Time (Military)
Baby's Name at Discharge	Mother's Date of Birth	Weeks Gest:	Medical Record #:
MOTHER'S Name (Last)	MOTHER'S Name (First, MI)	<input type="checkbox"/> Transfused Date: / /	Time (Military)
Street (PO Box)	City	<input type="checkbox"/> NCU	<input type="checkbox"/> Hypert
City	State	<input type="checkbox"/> Carnitine	<input type="checkbox"/> Meconium
Mother's Email	Mother's Phone # () -	Race (check all that apply): <input type="checkbox"/> Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact	Emergency Contact # () -	<input type="checkbox"/> White	<input type="checkbox"/> Pac. Isl.
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Asian	<input type="checkbox"/> Am. Ind.
Mother's Medical History:		<input type="checkbox"/> Other	
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> On Steroids	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> prenatal fetal echocardiogram	<input type="checkbox"/> postnatal echocardiogram performed
HistAg: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unknown		<input type="checkbox"/> birth weight < 1500 grams	


NEWBORN SCREENING LABORATORY

City: _____ State: _____ Zip: _____

PCP Phone Number: () - _____

Pulse ox: passed failed Date: / / Time (Military) _____

If not performed, reason: refused prenatal fetal echocardiogram postnatal echocardiogram performed




GIVE TO PARENT / LEGAL GUARDIAN

FOLD BACK DURING DRYING BUT DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN HANDLERS.

PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY

AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN



Total Form Height (all parts): 5" (127mm)

Total Form Length (Flap Folded): 9 5/8" (244.48mm)