

South Dakota Newborn Screening Specimen Collection Card


Free Screen Repeat Screen Check Infant's Initials (a la NICU) Collector's Initials Chart Number
 Infant's Last Name Infant's First Name Multiple Births Yes No Sex Date M F Sex M F Transferrable ANY level products Yes No Birth Date Month Day Year Birth Date Month Day Year Birth Date Month Day Year Birth Date Month Day Year Feeding Method Formula Breast UPO Ambitious Nutrition Other

BABY
 Mother's Last Name Mother's First Name Mother's Address City State Zip-Code
 Mother's Birth Date Month Day Year Mother's Phone Number or Collector's Phone Number Area Code Number Extension

MOTHER
 Submitting Facility's Name Facility Number Submitting Facility's Phone Number Area Code Number Extension
 Submitting Facility's Address Street City State Zip-Code
 Attending Health Care Provider Name Title Facility of Birth
 Submitting Health Care Provider's Phone Number Area Code Number Extension

IOWA NEONATAL METABOLIC SCREENING FORM **DO NOT WRITE IN THIS SPACE**

DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.
PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.



WYOMING 0037 EXPRESSION DATE YYYV-MM SOUTH DAKOTA 10938799 49251 4239149

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