MEDICAID **Newborn Screening** CHIP/CHARITY

TEXAS DEPARTMENT OF STATE HEALTH SERVICES Laboratory Services Section CLIA#45D0660644
FORM NBS 3 **Expires 09/01/2018.** Telephone # (800) 252-8023 ext. 7318

Please read the instructions on the back of this form before starting. USE BLACK INK. PRINT INFORMATION COMPLETELY, ACCURATELY, & LEGIBLY IN BLOCK CAPITAL LETTERS.

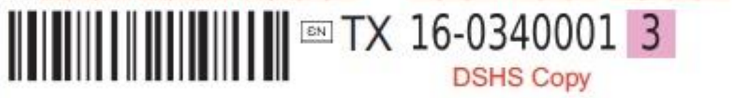
DSHS Lab No. For Texas DSHS Use Only

MOTHER INFORMATION

Mother's Last Name
Mother's First Name
Maiden Name
Social Security #
Mother's Birth Date MMDDYY
Medicaid Eligible (1-Yes, 2=No)
Medicaid No.
Street Address
Apt No.
City
Zip Code
State
Best Phone Number to Reach Mother
Newborn's Father's Last Name

BABY'S PRIMARY CARE PHYSICIAN INFORMATION

Physician Name (Last, First)
NPI No.
Street Address
Apt No.
City
Zip Code
State
Phone No.
Fax No.



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DSHS Copy

SPECIMEN REJECTED if NO Date of Collection or NO Newborn's Last Name is provided.

NEWBORN INFORMATION

Newborn's Last Name
First Name/Twin A or B
Medical Record No.
Birth Order (1-9), if Multiple
Birth - Date MMDDYY
Military Time
Birthweight (grams)
Previous Specimen Serial Number
Collection - Date MMDDYY
Military Time

Sex	Ethnicity	Status	Baby's Age at Time of Collection / Test
1. Male 2. Female	1. White 2. Af. Amer. 3. Hispanic 4. Asian 5. Am. Indian 6. Other	0. Normal 1. Sick/Premature 2. On Medications 3. Transfused 4. Both 1 & 2 5. Both 1 & 3 6. Both 2 & 3 7. All 1-3	1. Less than 7 days old 2. 7 days or older 3. Previous Abnormal: Enter Texas DSHS Laboratory No.
Feed 1. Breastmilk only 2. Formula only 3. TPN ± Milk 4. Breastmilk & Formula			

16-0340001

3N

SUBMITTER INFORMATION

NBS ID No. ________ / NPI No. ________

Name ________

Address ________ Affix Mailing Label or Print Return Address

City ________ TX Zip Code ________

Check to verify parent information & decision form distributed