MEDICAID **Newborn Screening** CHIP/CHARITY

TEXAS DEPARTMENT OF STATE HEALTH SERVICES Public Health Laboratory CLIA#45D0660644
FORM NBS 3 **Expires 01/31/2029.** Telephone # (888) 963-7111 ext. 7333

USE BLACK OR BLUE INK, PRINT INFORMATION COMPLETELY, ACCURATELY, & LEGIBLY IN BLOCK CAPITAL LETTERS. See back of form for instructions.

DSHS Lab No. For Texas DSHS Use Only

SPECIMEN REJECTED if NO Date of Collection is provided.

MOTHER INFORMATION

Mother's Last Name | Mother's First Name

Maiden Name

Mother's Birth Date M M D D Y Y | Medicaid Eligible (1-Yes, 2=No) | Medicaid No.

Street Address | Apt.

City | Zip Code | State

Best Phone Number to Reach Mother/Parent/Guardian

Email Address

BABY'S PRIMARY CARE PROVIDER INFORMATION

Provider Name (Last, First)

Phone No. | Fax No.

SN TX 240000001 7

DSHS Copy

NEWBORN INFORMATION

Newborn's Last Name | First Name/Twin A or B

Medical Record No. | Birth Order (1-9), if Multiple | Birth - Date | Military Time

Birthweight (grams) | Previous Specimen Serial Number | Collection - Date | Military Time

Sex	Feed	Ethnicity/Race
1. Male 2. Female 3. Ambiguous	1. Breastmilk only 2. Formula only 3. TPN ± Milk 4. Breastmilk & Formula 5. NPO	1. White 2. Af. Amer. 3. Hispanic 4. Asian 5. Am. Indian 6. Other

Gestational Age: Weeks | Days

For DSHS use only

Status: 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

Meconium Ileus: 1. Yes

Last Transfusion Date M M D D Y Y

SN 240000001

SUBMITTER INFORMATION

NBS Submitter ID Number: _ _ _ _ _ _ _ _

Name

Address — Affix Mailing Label or Print Return Address

City | TX | Zip Code

Check to verify parent information & decision form distributed ☐