SEE DIRECTIONS ON BACK. PLEASE PRINT.

DO NOT USE THIS AREA

HAWAII NEWBORN METABOLIC SCREENING PROGRAM
(808) 733-9069
RETURN TO: WASHINGTON STATE NEWBORN SCREENING
1610 NE 150TH STREET SHORELINE WA 98155-0729
DOH 951-152 (rev. 5/19)

MOTHER'S INFORMATION

LAST NAME

FIRST NAME

Street Address

City State Zip Code

Phone Birth Date / /

Maternal Steroids ◯ (within 7 days) Date last ____/____/____

MISCELLANEOUS INFORMATION

SUBMITTER ID

Collected at (facility):

H I - ____ ____ ____ ____

Code

Name

FOLLOW-UP CARE

PCP / Clinic ID:

H I - ____ ____ ____ ____

Code

Name

Specimen Taken By:

CHILD'S INFORMATION

Mo Day Yr Hr : Mn am pm

Birth: ____/____/____ ____:____ ◯ ◯

Collection: ____/____/____ ____:____ ◯ ◯

Name: _____ _____
First Last

Med Rec #: _____

Sex: M ◯ F ◯ Gestational Age _____ weeks

Birth Order: single ◯ if multiple A ◯ B ◯ ___ ◯

Birthweight: ____ ____ ____ ____ grams

Food Source (Fill in all that apply) Breast ◯ Lactose Formula ◯
Last 24 hours: NPO ◯ Soy Formula ◯ Other: _____ ◯

Race/Ethnicity: (Fill in all that apply)
White ◯ Black ◯ Asian ◯ Hawaiian / Pacific Islander ◯
Native American ◯ Other ◯ Unknown ◯ Hispanic ◯

CHILD'S SPECIAL CONSIDERATIONS

NICU ◯ HA/TPN ◯ (within 24 hours) Steroids ◯ (within 7 days) Antibiotics ◯ (within 24 hours)

Transfused (RBC) ◯ Date last ____/____/____

SN HI1000001x

Expires 2022-05-31

SN HI1000001x

SATURATE EACH CIRCLE COMPLETELY BEFORE MOVING TO THE NEXT