MEDICAID

Newborn Screening

CHIP/CHARITY

TEXAS DEPARTMENT OF STATE HEALTH SERVICES Laboratory Services Section CLIA#45D0660644
FORM NBS 3 **Expires 03/31/2026.** Telephone # (888) 963-7111 ext. 7333

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

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 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

BABY'S PRIMARY CARE PHYSICIAN INFORMATION

Physician Name (Last, First)

Street Address | Ste.

City | Zip Code | State

Phone No. ___-___-___ Fax No. ___-___-___

SN TX 21-0211201 8

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 M M D D Y Y | Military Time

Birthweight (grams) | Previous Specimen Serial Number ___-___ | Collection - Date M M D D Y Y | Military Time

Sex	Feed	Ethnicity
1. Male 2. Female	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; 2. No

SN 21-0211201

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 ☐