

SEE DIRECTIONS ON BACK. PLEASE PRINT.

DO NOT USE THIS AREA

NEWBORN SCREENING
WASHINGTON STATE DEPT. OF HEALTH
P.O. BOX 55729 (1610 NE 150TH ST)
SHORELINE, WA 98155-0729 www.doh.wa.gov/nbs
Phone: 206-418-5410 Toll Free: 1-866-660-9050



MOTHER'S INFORMATION	CHILD'S INFORMATION
DOE LAST NAME	Mo Day Yr Hr : Mn am pm Birth: 1 / 1 / 09 3 : 25 <input checked="" type="checkbox"/> <input type="checkbox"/>
JANE FIRST NAME	Collection: 1 / 15 / 09 12 : 45 <input type="checkbox"/> <input checked="" type="checkbox"/>
MISCELLANEOUS INFORMATION	Name: <u>Janette</u> First Last
Mother on steroids, Baby is breastfeeding	Med Rec #: <u>T 1 1 1 1 1 1 1 1 1 1</u>
SUBMITTER INFORMATION	Sex: M <input type="checkbox"/> F <input checked="" type="checkbox"/> Twin: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> <input type="checkbox"/>
COLLECTED AT: <u>N.W. Hospital</u>	Birthweight: <u>2 7 4 5</u> grams
ID: <u>H -- 130</u>	Race: White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> NaAm <input type="checkbox"/> Other <input type="checkbox"/>
OUTPATIENT PROVIDER INFORMATION	Hispanic: Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
WELL-CHILD CARE WITH: <u>Dr. J. Does</u>	SPECIAL CONSIDERATIONS
ID: <u>P -- 00099999</u>	NICU <input checked="" type="checkbox"/> HATPN <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input checked="" type="checkbox"/>
	Transfused <input checked="" type="checkbox"/> (date last) <u>1 / 13 / 09</u>

IF TEST IS REFUSED BY PARENT, CHECK HERE (SIGNATURE IS REQUIRED ON BACK OF FORM) DOH304001 (REV. 04/08)

On Back of Card



SN 15573503

Alstrom 226

LOT 8040201 / 0901093

SN 15573503



FILL EACH CIRCLE COMPLETELY BEFORE MOVING TO THE NEXT

03/12

REFUSAL OF TESTING

Parents or guardians may refuse testing on the basis of religious practices or tenets as provided by RCW 70.83.

NEWBORN TESTING FOR HERITABLE DISEASES IS HEREBY REFUSED.

I am the parent or guardian of:

Child's Name

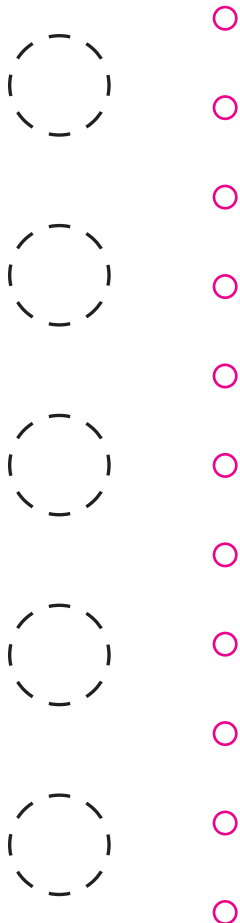
Mother's Name

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed:

Parent or Guardian

Date



Newborn Screening Specimen Collection Card Sample

MOTHER'S INFORMATION

- Mother's Last Name: **DOE**
- Mother's First Name: **JANE**
- Miscellaneous Information: **Mother on steroids, baby is breastfeeding**
- Submitter Information
 - Collected At: **NW Hospital**
 - ID: **H - 130**
- Outpatient Provider Information
 - Well-Child care with: **Dr J. Does**
 - ID: **P-00099999**
- If test is refused, check the box below provider ID:

The miscellaneous field may have any information that you feel will be helpful.

Look up submitter & provider ID numbers on our website at <http://www.doh.wa.gov/ehspl/phl/newborn/providerdirectorymap.htm>.

If refusing, check mark denotes **yes**. Flip card over, and have a parent sign and date on the back.
****Be sure card is sent to state lab****

CHILD'S INFORMATION

- Birth
 - Date: **1/1/09**
 - Time: **3:25 am**
- Collection
 - Date: **1/15/09**
 - Time: **12:45 pm**
- Name: **Janette**
- Med Rec #: **T111111111**
- Sex: **White**
- Twin:
- Birthweight: **2745**
- Race: **White**
- Hispanic: **Yes**
- Special Considerations
 - NICU: **Yes**
 - HA/TPN:
 - Steroids:
 - Antibiotics: **Yes**
 - Transfused: **Yes** (date last) **1/13/09**

If baby is a single birth, leave check boxes blank.

OK to enter weight in pounds and ounces, just make sure you clearly note that it is in pounds and ounces. Example: **6 lbs 8 ozs**

OK to leave unchecked if you do not know the race or ethnicity of the baby.

These fields only apply to the baby.