Live* Birth Roster (Weekly)

FAX every Monday morning to:
Newborn Screening Laboratory
Fax (206) 418-5415
ATTN: Gauri Gupta
Phone (206) 418-5410

Sunday: _____ through Saturday: _____
mm/dd/yyyy mm/dd/yyyy

Birth Facility: _____ ID #: **H or B-**_____

Person reporting:_____ Fax _____ Phone _____

Instructions: Please **Print or Type** a list of all births that occurred in this birth facility **during the previous week (Sun.-Sat.).**
If no births occurred during a given week, please complete and fax a roster stating "no births"
***** Please **Do Not list Stillbirths***
Under Comments: Please note **Transfers** (hospital and date), **Deaths** (include date), **Adoptions/Surrogate/Foster** and the **barcode number** from the Newborn Screening specimen card

Date of Birth mm/dd/yyyy	Mother's Last Name/ And Baby's Last Name (if different)	Sex M/F	If Twin A/B/C	Mother's First Name	Comments

Washington State Department of Health

Thank You For Your Cooperation!