



Newborn Screening Specimen Collection Card Sample

SEE DIRECTIONS ON BACK. PLEASE PRINT.

DO NOT USE THIS AREA

WASHINGTON STATE NEWBORN SCREENING

MOTHER'S INFORMATION	CHILD'S INFORMATION
DOH <small>LAST NAME</small> JANE <small>FIRST NAME</small> Maternal Steroids <input checked="" type="checkbox"/> (date last) <u>2</u> / <u>18</u> / <u>11</u>	Birth: <u>2</u> / <u>18</u> / <u>11</u> <u>4:36</u> <input checked="" type="checkbox"/> <input type="checkbox"/> <small>Mo Day Yr Hr : Mn am pm</small> Collection: <u>2</u> / <u>19</u> / <u>11</u> <u>1:12</u> <input type="checkbox"/> <input checked="" type="checkbox"/> <small>First Last</small> Name: <u>Joe</u> <u>Smith</u> Med Rec #: <u>M</u> <u>1</u> <u>2</u> <u>3</u> <u>4</u> <u>5</u> <u>6</u> Sex: M <input checked="" type="checkbox"/> F <input type="checkbox"/> Birth Order: single <input checked="" type="checkbox"/> if multiple A <input type="checkbox"/> B <input type="checkbox"/> <input type="checkbox"/> Birthweight: _____ grams OR <u>7</u> lbs. <u>0</u> <u>8</u> oz. Race/Ethnicity: (Check all that apply) White <input type="checkbox"/> Black <input checked="" type="checkbox"/> Asian <input type="checkbox"/> NaAm <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input checked="" type="checkbox"/>
MISCELLANEOUS INFORMATION	
Adoptive mom is Jill Smith, baby is on soy formula	
SUBMITTER INFORMATION	
COLLECTED AT: <u>Health Hospital</u> ID: <u>H -- 0004</u>	
OUTPATIENT PROVIDER INFORMATION	
WELL-CHILD CARE WITH: <u>Dr. J. Does</u> ID: <u>P -- 00099999</u>	
	CHILD'S SPECIAL CONSIDERATIONS
	NICU <input checked="" type="checkbox"/> HA/TPN <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Transfused <input checked="" type="checkbox"/> (date last) <u>2</u> / <u>18</u> / <u>11</u>

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

XXXXXXX

LOT 0120201 / XXXXXXXX Ahlstrom 226
 SN XXXXXXXX

FILL EACH CIRCLE COMPLETELY BEFORE MOVING TO THE NEXT

On Back of Card

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

MM/YY

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



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MOTHER'S INFORMATION

- Mother's Last Name: **DOH**
- Mother's First Name: **JANE**
- Maternal Steroids: **Yes** (date last) **2/18/11**
- Miscellaneous Information: **Adoptive mom is Jill Smith, baby is on soy formula**
- Submitter Information
 - Collected At: **Health Hospital**
 - ID: **H - 0004**
- 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/ehsphl/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: **2/18/11**
 - Time: **4:36 am**
- Collection
 - Date: **2/19/11**
 - Time: **1:12 pm**
- Name: **Joe Smith**
- Med Rec #: **M123456**
- Sex: **Male**
- Birth Order: **Singleton**
- Birthweight: **7lbs. 08oz.**
- Race/Ethnicity: **Black** and **Hispanic**
- Special Considerations
 - NICU: **Yes**
 - HA/TPN:
 - Steroids:
 - Antibiotics:
 - Transfused: **Yes** (date last) **2/18/11**

OK to enter weight in grams OR pounds and ounces.

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

These fields only apply to baby.