



**Division of Newborn Screening and Genetics
Newborn Screening Status Report**

Please complete the following information and fax the report to Pennsylvania Department of Health, Newborn Screening Follow-up Program (NSFP), at 717-724-6995.

Submitter: _____ **Sender's name:** _____

Baby's name: (boy) (girl) _____

DOB: _____ **Medical record #:** _____

Mom's name: _____ **Initial filter paper #:** _____

If parent refusal or newborn expires, please include the following information:

Mom's date of birth: _____ **Phone number** _____

Mom's address: _____

PCP Name: _____ **Phone Number:** _____

Repeat filter paper #: _____ **Date of collection:** _____

Transferred to: _____

Expired date: _____

Recent blood transfusion; date: _____

CCHD screen: **Pass** **Fail** **Date:** _____ **Time:** _____

If not performed, check reason: **Refused** **Prenatal fetal echocardiogram**

Postnatal echocardiogram performed **Birth weight <1500 grams**

Other: _____

If you require assistance in follow-up for this infant, please contact the NSFP staff at 717-783-8143.

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