



**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.

NOTE: The information contained in this transmission is intended only for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this transmitted information is strictly prohibited and that the contents should be returned to the sender immediately. In this regard, please notify me by telephone at the above number immediately. Thank you.