

Pennsylvania Department of Health **TOP COPY FOR LAB; SUBMITTER MAY KEEP YELLOW COPY**
 Newborn Screening Specimen
 Phone: (717) 783-8143 • TTY: (717) 783-6514 Monitor for _____

SN PA190375201

PENNSYLVANIA DEPT. OF HEALTH [VD] EXPIRES 2026-03-31

<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	
Birth Facility/Out-of-hospital Provider Name		Code	
Submitter Name		Code	
Address if no CODE given		Birth Date: ____/____/____ Time (Military): ____:____	
BABY'S Name (Last)		BABY'S Name (First)	
BABY'S Last Name at Discharge		BABY'S First Name at Discharge	
MOTHER'S Name (Last)		MOTHER'S Name (First, MI)	
Street (PO Box)		City State Zip	
Mother's E-mail		Mother's Phone # () -	
Emergency Contact		Emergency Contact # () -	
Mother's Date of Birth: ____/____/____		Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother's Medical History: <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> On Steroids <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____ HBsAg: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unknown		AFFIX ACCESSION LABEL HERE	
Transfusion Type: PRBC Date: ____/____/____ Transfusion Type: FFP Date: ____/____/____ Transfusion Type: PLT Date: ____/____/____ Time (Military): ____:____ Time (Military): ____:____ Time (Military): ____:____ <input type="checkbox"/> Hypernat <input type="checkbox"/> Carnitine <input type="checkbox"/> NCU <input type="checkbox"/> Meconium ileus Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No Newborn PCP / Practice Name Street (PO Box) City State Zip PCP Phone Number () - Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed Date: ____/____/____ Time (Military): ____:____ If not performed ↓ reason: <input type="checkbox"/> refused <input type="checkbox"/> prenatal fetal echocardiogram <input type="checkbox"/> postnatal echocardiogram performed <input type="checkbox"/> birth weight <1500 grams			



GIVE TO PARENT / LEGAL GUARDIAN

FOLD BACK DURING DRYING BUT
DO NOT REMOVE THIS COVER FLAP.
 IT IS FOR THE PROTECTION OF THE SPECIMEN HANDLERS.

PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY

AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN

