

Check one box to indicate if this is an initial or repeat specimen

Write the Newborn's Last Name

Write the Newborn's Date of Birth

Write the Date the Specimen was Collected

Write the Time the Specimen was Collected

Write the Mother's Name, Address, Birthdate, Phone # and Alternate Phone #

Write the Birthing/Submitting Facility's Name, Address, Phone #, and Fax #

Write the Newborn's Time of Birth

Write the Newborn's Birth and Collection Weight in Grams

Write the Newborn's Gestational Age

Write the Newborn's First Name

Check the Sex of the Newborn

Write the Newborn's Medical Record Number

Check any Medical Interventions used for the Newborn

If the Newborn was a multiple Birth Check A for first, B for Second or Enter Birth order in the Space Provided

Check the Race and Ethnicity of the Newborn

**FOR NEONATAL SCREENING ONLY**  
 COMPLIANT WITH CLSI STANDARDS  
 FORM KS #740  
 REV 03/02

**KANSAS DEPARTMENT OF HEALTH & ENVIRONMENTAL LABORATORIES**

SELECT ONE  
 INITIAL  REPEAT

**NEWBORN INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_  
 BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ BIRTH TIME (MILITARY): \_\_\_\_\_  
 COLLECTION DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ COLLECTION TIME (MILITARY): \_\_\_\_\_  
 RACE - Check all that apply:  WHITE  BLACK  ASIAN/Pacific Islander  NATIVE AMERICAN/Alaskan Native  Unknown  Other  HISPANIC / LATIN  NON-HISPANIC/LATIN

BIRTH WT IN GRAMS: \_\_\_\_\_ GESTATIONAL AGE: \_\_\_\_\_ SEX:  M  F  N/S  
 COLLECTION WT IN GRAMS: \_\_\_\_\_ INFANT IN NICU  INFANT ON TPN  TRANSFUSED  DATE TRANSFUSED: \_\_\_\_\_ ANTIBIOTICS  MULTIPLE BIRTHS?  YES  NO

MEDICAL RECORD NUMBER: \_\_\_\_\_

**MOTHER INFORMATION**

LAST NAME, FIRST NAME: \_\_\_\_\_ STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_  
 BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE #: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ ALTERNATE PHONE #: \_\_\_\_\_

**SUBMITTING BIRTHING FACILITY NAME**

NAME OF SUBMITTING FACILITY: \_\_\_\_\_ NEONATAL ID #: \_\_\_\_\_  
 STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_ COLLECTOR: \_\_\_\_\_

**NEWBORN PRIMARY CARE PHYSICIAN/PROVIDER**

LAST NAME, FIRST NAME: \_\_\_\_\_ STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_  
 ZIP CODE: \_\_\_\_\_ PROVIDER NPI: \_\_\_\_\_  
 PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

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Write the Neonatal ID of the Birthing/Submitting Facility

Write the Name or Initials of the Collector

Write the Primary Care Physician's/Provider's Name, Address, NPI, Phone #, and Fax #