

South Dakota Newborn Screening Specimen Collection Card

Iowa Neonatal Metabolic Screening Form

BABY

First Screen Repeat Screen Check if Infant is to NICU Collector's Initials _____ Chart Number _____

Infant's Last Name _____ Birth Date: Month _____ Day _____ Year _____ Birth Time (24 hour clock) _____

Infant's First Name _____ Sex: M F Collection Date: Month _____ Day _____ Year _____ Collection Time (24 hour clock) _____

Multiple Births: Yes No Sex Order: 1 2 3 etc. _____ Current Weight (GMS) _____ Transfusion ANY blood products: Yes No If yes, date of transfusion: Month _____ Day _____ Year _____ Gestational Age _____

Feeding Method: Formula Breast NPO Parenteral Nutrition Other _____

MOTHER

Mother's Last Name _____ Mother's Maiden Name _____

Mother's First Name _____ Mother's Birth Date: Month _____ Day _____ Year _____ Mother's Phone Number or Contact's Phone Number: Area Code _____ Number _____

Mother's Address: Street _____ City _____ State _____ Zip Code _____

SUBMITTING FACILITY

Submitting Facility's Name _____ Facility Number _____ Submitting Facility's Phone Number: Area Code _____ Number _____

Submitting Facility's Address: Street _____ City _____ State _____ Zip Code _____

Attending Health Care Provider _____ DO NOT WRITE IN THIS SPACE

Attending Health Care Provider's Phone Number: Area Code _____ Number _____ Facility of Birth _____

IAC400000

DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.
PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.

