SOUTH DAKOTA DEPARTMENT OF HEALTH
Every South Dakotan Healthy and Strong

NBS Report PCP Request Form

This is an online fillable form

If you have questions please contact: dohnewbornscreening@state.sd.us

Child/Patient Information

Child/Patient Name:	
Date of Birth:	Sex:
Birth Facility:	
Multiple Birth: ☑ YES ☐ NO	Birth Order: (e.g. Twin A, Twin B)
Mother's Last and First Name at Child's Birth:	

Provider Information

Provider Requesting Name:
Facility Name:
Provider's NP#:
Credentials (MD, DO, NP):
Provider's Phone Number:
Fax Number where report to be sent:

I certify the child listed above is my patient and hereby grant permission to the South Dakota Department of Health Newborn Screening Program to release the newborn screening record, including laboratory test reports of the child stated above, for diagnosis and treatment purposes only.

■ Verbal or written consent obtained from parent.

Signature of Health Care Provider _____ Date _____