

6242506 / 10534539  
Whatman 903® LOT # W-051



# 1st

Newborn Screening Specimen

Colorado Dept of Public Health & Environment Laboratory • P.O. Box 17123 • Denver, CO 80217 • (303) 692-3670

To ensure proper patient identification and matching, use of the **NBS 1<sup>st</sup> and 2<sup>nd</sup> forms is preferred.**

If the **Supplemental Form** is used, follow instructions for matching patient information **exactly** as stated at the bottom of this page.

<b>Infant</b>	Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	If multiple A,B. etc	AKA - Last, First
	Birth - Date/Time / / : AM PM	Specimen Collected - Date/Time / / : AM PM	Transfused? <input type="checkbox"/> Yes <input type="checkbox"/> No		Present weight gms
<b>Physician</b>	Infant's Physician		Physician Phone ( )		Medical Record or other #
	Address - Street		City	State	Collected by:
<b>Mother</b>	Last Name		First Name		Mother's Phone ( )
<b>Submitter</b>	Facility/Clinic Name		Facility Phone ( )		Mother's Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other
	Facility/Clinic Address - Street		City	State	Zip

(Results and bills will be sent to submitter)

**SUBMITTER COPY**  
After Data Entry Is Completed, Remove This Copy And Retain For Your Records

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# 2nd

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<b>Infant</b>	Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	If multiple A,B. etc	AKA - Last, First
	Birth - Date/Time / / : AM PM	Specimen Collected - Date/Time / / : AM PM	Transfused? <input type="checkbox"/> Yes <input type="checkbox"/> No		Present weight gms
<b>Physician</b>	Infant's Physician		Physician Phone ( )		Medical Record or other #
	Address - Street		City	State	Collected by:
<b>Mother</b>	Last Name		First Name		Mother's Phone ( )
<b>Submitter</b>	Facility/Clinic Name		Facility Phone ( )		Mother's Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other
	Facility/Clinic Address - Street		City	State	Zip

(Results will be sent to submitter)

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6207105  
Whatman 903® Lot # W-041



# SUPPLEMENTAL FORM

Newborn Screening Specimen

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**ALL** information provided on this **Supplemental Form** is critical to proper patient identification.

When using this form, pay special attention to accurately match ALL of areas with the initial 1<sup>st</sup> screen form submitted.

<b>Infant</b>	Last Name	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	If multiple A,B. etc	AKA - Last, First
	Birth - Date/Time / / : AM PM	Specimen Collected - Date/Time / / : AM PM	Transfused? <input type="checkbox"/> Yes <input type="checkbox"/> No		Present weight gms
<b>Physician</b>	Infant's Physician		Physician Phone ( )		Medical Record or other #
	Address - Street		City	State	Collected by:
<b>Mother</b>	Last Name		First Name		Mother's Phone ( )
<b>Submitter</b>	Facility/Clinic Name		Facility Phone ( )		Mother's Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other
	Facility/Clinic Address - Street		City	State	Zip

(Results will be sent to submitter)

Must accurately match the names from 1<sup>st</sup> screen

Birth date and time must accurately match the 1<sup>st</sup> screen

AKA Baby Last Name is very important!

Mother's names must accurately match the names from 1<sup>st</sup> screen

This form is for the collection of a newborn screening specimen

