

EXPIRATION DATE
2020-02-28

Use black or blue ink ball point pen only.
See full instructions for completion of form on back page.

SN 1710050
ODH #450 Rev 10-2018

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Oklahoma Newborn Screening (NBS) Form

To order forms, call the OSDH NBS Program (405) 271-5070

DO NOT WRITE HERE

<input type="checkbox"/> First Screen <input type="checkbox"/> Repeat Screen Previous NBS Lab # _____		MEDICAL/FEEDING HISTORY (Check all that apply)	
Not Screened Due To <input type="checkbox"/> Refused <input type="checkbox"/> Expired ___/___/___		<input type="checkbox"/> Transfusion Date ___/___/___ Time ___:___ (24 Hr Clock)	
<input type="checkbox"/> Transferred ___/___/___ to _____		<input type="checkbox"/> NICU/SCN <input type="checkbox"/> Lactose-Free Formula (Soy)	
Tests Requested <input type="checkbox"/> All Tests <input type="checkbox"/> HGB Only <input type="checkbox"/> GALT <input type="checkbox"/> Phe Monitor <input type="checkbox"/> CFTR		<input type="checkbox"/> TPN/SNAP <input type="checkbox"/> Meconium Ileus	
		<input type="checkbox"/> Lipids/Carnitine/MCT <input type="checkbox"/> Family History of CF	
BABY'S INFORMATION			
Last Name _____		First Name _____	
Birth Date ___/___/___ Time ___:___ (24 Hr Clock)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Collection Date ___/___/___ Time ___:___ (24 Hr Clock)		Race (Check all as apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander	
Medical Record # _____		Gest. Age _____ Birth Wt. (gm) _____ Multiple Birth Order <input type="checkbox"/> A-	
MOTHER'S/GUARDIAN'S INFORMATION			
<input type="checkbox"/> DHS Custody <input type="checkbox"/> Adoption		Last Name _____ First Name _____	
Address _____			Apt. # _____
City _____		State _____	Zip _____
Telephone # () - _____		Alternate Telephone # () - _____	
Mother's Date of Birth ___/___/___		Mother's Medicaid ID # _____	Mother's Last 4 of SSN _____
PROVIDER'S INFORMATION			
Physician Ordering NBS (Last, First) _____		Provider ID # _____	
Primary Care/Follow-up Physician (Last, First) _____		Provider ID # _____	
SUBMITTER'S INFORMATION			
Submitting Facility's/Provider's ID # _____			
Submitter's Name/Address _____			
HEARING SCREEN			
Date of Final Screen ___/___/___			
Right Ear: <input type="checkbox"/> Pass <input type="checkbox"/> Refer		Left Ear: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Screen Method <input type="checkbox"/> ABR <input type="checkbox"/> OAE		Hearing Risk Status (Select all that apply) <input type="checkbox"/> Family History <input type="checkbox"/> In Utero Infection <input type="checkbox"/> Craniofacial Anomalies <input type="checkbox"/> ECMO <input type="checkbox"/> Both Hyperbilirubinemia AND Exchange Transfusion <input type="checkbox"/> NICU	
If not screened, reason <input type="checkbox"/> Delayed <input type="checkbox"/> Discharged <input type="checkbox"/> No Supplies <input type="checkbox"/> Refused <input type="checkbox"/> Technical Problem			
Do not write in this box			