

**INFANTS INFORMATION**

1. Infant's Last Name: \_\_\_\_\_ Infant's First Name: \_\_\_\_\_

2. Sex:  M  F 3. Date of Birth: MM DD YY 4. Birth Time: : 24 Hour Clock

5. Birthweight in Grams: \_\_\_\_\_ 6. If Multiple Birth Indicate Birth Order: A-H  7. Infant's Medical Record or I.D.: \_\_\_\_\_

8. Provider ID: \_\_\_\_\_ 9. Infant's Provider or Physician's Name: \_\_\_\_\_

10. Mom's Medicaid Number: \_\_\_\_\_ 11. ( ) - Provider's Phone Number: \_\_\_\_\_

**MOMS INFORMATION**

1. Mom's Last Name, First Name: \_\_\_\_\_ 2. Mom's Age: \_\_\_\_\_

3. Mom's Address: \_\_\_\_\_ 4. Apt. #: \_\_\_\_\_

5. Mom's City: \_\_\_\_\_ 6. State: \_\_\_\_\_ 7. Zip: \_\_\_\_\_

8. ( ) - Mom's Telephone or Contact: \_\_\_\_\_ 9. Mom's Social Security #: \_\_\_\_\_

10. Mom's Race/Ethnic:  1. White  2. Black  3. Hispanic  4. Asian  5. American Indian  6. Other

**DO NOT WRITE IN THIS BOX**

**SPECIMEN INFORMATION**

1. Collection Date: MM DD YY Collection Time: : 24 Hour Clock

2. Transfusion Date: MM DD YY Time: : 24 Hour Clock

Do not write in this box

3. Has a previous metabolic blood test been done anywhere?  Yes  No  
 Previous OSDH Lab Number: \_\_\_\_\_

4. Check all that apply at time of screening:  
 TPN  Antibiotics  Lactose-Free Formula (Soy)  
 Meconium ileus  Family History of CF

5. Test Requested:  
 All Tests  HGB Only  GALT  CFTR  Phe Monitor

Adoption (check if baby is being adopted)  
 (See back of form for instructions)

Pulse Oximetry (CCHD) Screen  
 Not Performed  Pass  Fail

SUBMITTING HEALTH PROVIDER ID # \_\_\_\_\_  
 Return to Submitter at this address: \_\_\_\_\_

**Hearing Screening Results:**

<u>Right Ear</u>	<u>Left Ear</u>	<u>Screen Method</u>
<input type="checkbox"/> Pass	<input type="checkbox"/> Pass	<input type="checkbox"/> ABR <input type="checkbox"/> Other (Specify) _____
<input type="checkbox"/> Refer	<input type="checkbox"/> Refer	<input type="checkbox"/> OAE

If not screened, reason:  
 Technical problem  No equipment  Delayed  
 Caregiver refused  Baby discharged  Other \_\_\_\_\_

Hearing risk status—Check all that apply:  
 Blood relatives of the infant have a permanent hearing loss that began at birth or in early childhood.  
 Infant is suspected of having a congenital infection (neonatal herpes, cmv, rubella, syphilis, toxoplasmosis).  
 Infant has craniofacial anomalies (pinna/ear canal abnormality, cleft lip/palate, hydrocephalus).  
 Infant had exchange transfusion.  
 Infant has serum bilirubin level  $\geq 15$  mg/dL.  
 Infant was placed in a Level II or III nursery for more than 24 hours.