

2018 MA  
2021-08-31

USE BALL-POINT PEN  FIRST SPECIMEN  REPEAT SPECIMEN



MA1201401

Consents  Refuses

HOSPITAL CODE HOSPITAL OF BIRTH CHECK IF SUBMITTER

SN

Recorder's Initials: \_\_\_\_\_

BABY'S MEDICAL RECORD NO. HOSPITAL OF TRANSFER CHECK IF SUBMITTER

BABY'S NAME (Last) (First)

MOTHER'S NAME (LAST)

SEX  M  F  Single Birth  Multiple Birth  A  B  C

MOTHER'S NAME (FIRST) MOTHER'S BIRTH DATE

BIRTH DATE    mo /    day /    yr TIME   :    AM  PM

STREET (P.O. BOX)

SPECIMEN DATE    mo /    day /    yr TIME   :    AM  PM

CITY/TOWN STATE ZIP

GESTATIONAL AGE \_\_\_\_\_ weeks

HOME TEL. (    ) CELL (    )

BIRTH WEIGHT grams \_\_\_\_\_ OR lbs/oz \_\_\_\_\_ / \_\_\_\_\_

MOTHER'S MEDICAL HISTORY  THYROID DISEASE  
HEPATITIS B ANTIGEN STATUS  POSITIVE  UNKNOWN  NEGATIVE  
FEEDING HISTORY  BREAST, EVER  BREAST, CURRENTLY  FORMULA \_\_\_\_\_ TYPE

CURRENT WEIGHT grams \_\_\_\_\_ OR lbs/oz \_\_\_\_\_ / \_\_\_\_\_

HEEL STICK  OTHER \_\_\_\_\_

BABY'S DOCTOR CHECK IF SUBMITTER

AT TIME OF SPECIMEN COLLECTION, **BABY:**  
(CHECK ALL BOXES THAT APPLY)

STREET (P.O. BOX)

IS LESS THAN 24 HOURS OF AGE → ANOTHER SAMPLE REQUIRED BY 48 HRS OF AGE  
 HAS EVER BEEN TRANSFUSED  
 TRANSFUSED IN LAST 48 HOURS } SEE COLLECTION GUIDELINES  
 IS IN NICU/SPECIAL CARE

CITY/TOWN STATE ZIP

COLLECTOR'S INITIALS

COMMENTS: \_\_\_\_\_ 2018 MA

TELEPHONE (    )

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