

2018 MA  
2021-08-31

USE BALL-POINT PEN  FIRST SPECIMEN  REPEAT SPECIMEN



MA1201401

Consents  Refuses

HOSPITAL CODE	HOSPITAL OF BIRTH	CHECK IF SUBMITTER <input type="checkbox"/>
BABY'S MEDICAL RECORD NO.	HOSPITAL OF TRANSFER	CHECK IF SUBMITTER <input type="checkbox"/>

SN

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

MOTHER'S NAME (LAST)

BABY'S NAME (Last) (First)

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

SEX  M  F  Single Birth  Multiple Birth  A  B  C

STREET (P.O. BOX)

BIRTH DATE mo / day / yr TIME : AM PM

CITY/TOWN STATE ZIP

SPECIMEN DATE mo / day / yr TIME : AM PM

HOME TEL. ( ) CELL ( )

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

MOTHER'S MEDICAL HISTORY

THYROID DISEASE

HEPATITIS B ANTIGEN STATUS

POSITIVE  UNKNOWN  NEGATIVE

FEEDING HISTORY

BREAST, EVER

BREAST, CURRENTLY

FORMULA \_\_\_\_\_ TYPE

BIRTH WEIGHT grams OR lbs/oz /

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
  - IS IN NICU/SPECIAL CARE
- SEE COLLECTION GUIDELINES

CITY/TOWN STATE ZIP

COLLECTOR'S INITIALS

COMMENTS: 2018 MA

TELEPHONE ( )

SCREENING LAB COPY

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