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

SN 1710050

Oklahoma Newborn Screening (NBS) Form

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

DO NOT WRITE HERE

☐ First Screen ☐ Repeat Screen Previous NBS Lab #_____

Not Screened Due To ☐ Refused ☐ Expired ____ / ____ / ____
☐ Transferred ____/____/____ to _____

Tests Requested
☐ All Tests ☐ HGB Only ☐ GALT ☐ Phe Monitor ☐ CFTR

BABY'S INFORMATION

Last Name | First Name

Birth Date ____ / ____ / ____ Time ____:____ *(24 Hr Clock)*

Collection Date ____ / ____ / ____ Time ____:____ *(24 Hr Clock)*

Sex ☐ Male ☐ Female ☐ Unknown

Race *(Check all as apply)* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

Medical Record # | Gest. Age | Birth Wt. (gm) | Multiple Birth Order ☐ A-

MOTHER'S/GUARDIAN'S INFORMATION

☐ DHS Custody ☐ 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 #

MEDICAL/FEEDING HISTORY *(Check all that apply)*

☐ Transfusion Date ____ / ____ / ____ Time ____:____ *(24 Hr Clock)*
☐ NICU/SCN ☐ TPN/SNAP ☐ Lipids/Carnitine/MCT
☐ Lactose-Free Formula (Soy) ☐ Meconium Ileus ☐ Family History of CF

PULSE OXIMETRY/CCHD SCREEN

☐ Pass ☐ Fail ☐ Not Performed ☐ Refused ☐ Echo

Do not write in this box

HEARING SCREEN

Date of Final Screen ____ / ____ / ____

Right Ear: ☐ Pass ☐ Refer Left Ear: ☐ Pass ☐ Refer

Screen Method ☐ ABR ☐ OAE

If not screened, reason
☐ Delayed ☐ Discharged ☐ No Supplies ☐ Refused ☐ Technical Problem

Hearing Risk Status *(Select all that apply)*
☐ Family History ☐ In Utero Infection ☐ Craniofacial Anomalies ☐ ECMO ☐ Both Hyperbilirubinemia AND Exchange Transfusion ☐ NICU

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #

Submitter's Name/Address