SN

Oklahoma Newborn Screening (NBS) Form

To order forms, call the OSDH NBS Program (405) 444-6494

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

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

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

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 that apply)* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

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

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

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

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #

Submitter's Name/Address

PROVIDER'S INFORMATION

Physician Ordering NBS (Last, First) | Provider ID#

Primary Care/Follow-up Physician (Last, First) | Provider ID #