



CALIFORNIA NEWBORN SCREENING TEST REQUEST FORM (CDPH 4409 12/08-NBS-I(D))



PRIMARY LANGUAGE (Fill only ONE circle): <input type="radio"/> ENGLISH <input type="radio"/> SPANISH <input type="radio"/> OTHER (Specify) _____	
FACILITY/SUBMITTER DRAWING SPECIMEN: _____ HOSPITAL/ SUBMITTER CODE _____	
REASON FOR TEST (Fill only ONE circle): <input type="radio"/> INITIAL SPECIMEN <input type="radio"/> REPEAT OF INADEQUATE SPECIMEN <input type="radio"/> REPEAT OF EARLY (<12 HRS) SPECIMEN <input type="radio"/> OTHER (Specify) _____	
NEWBORN'S BIRTH DATE ____/____/____	NEWBORN ON TPN/HYPERAL or AMINO ACIDS AT TIME OF COLLECTION? <input type="radio"/> NO <input type="radio"/> YES
DATE SPECIMEN COLLECTED ____/____/____	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE
TYPE OF SPECIMEN <input type="radio"/> HEELSTICK <input type="radio"/> OTHER (Specify) _____	BIRTH WEIGHT: ____/____/____ GMS
IF COLLECTED AT <12HRS OF AGE, REASON: <input type="radio"/> TO BE TRANSFUSED <input type="radio"/> OTHER (Specify) _____	ALL FEEDING SINCE BIRTH (Fill only ONE circle): <input type="radio"/> ONLY HUMAN MILK <input type="radio"/> ONLY FORMULA <input type="radio"/> HUMAN MILK & FORMULA
RBC TRANSFUSION BEFORE COLLECTION: <input type="radio"/> NO <input type="radio"/> YES if YES, date/time transfusion completed: ____/____/____	NURSERY TYPE <input type="radio"/> NICU <input type="radio"/> OTHER <input type="radio"/> REGULAR NURSERY
MEDICAL RECORD # _____	INITIALS OF COLLECTOR _____

**ALL FEEDING SINCE BIRTH
(Fill only ONE Circle):**

- ONLY HUMAN MILK
- ONLY FORMULA
- HUMAN MILK & FORMULA

INSTRUCTIONS

ALL FEEDING SINCE BIRTH: Include all feeding from birth to collection. Human milk includes breastfeeding, mother's own expressed milk and banked human milk. If newborn has had neither human milk, nor formula leave this section blank.