NOTIFICATION OF REGISTRATION OF BIRTH WHICH OCCURRED OUT OF A LICENSED HEALTH FACILITY (NBS-OH)

THIS FORM IS USED FOR CLINICAL FOLLOW-UP

PLEASE SEND THIS FORM IMMEDIATELY AFTER REGISTERING THE BIRTH (DO NOT BATCH MAIL).

PLEASE PRINT USING ALL CAPITAL LETTERS

TO: LOCAL HEALTH OFFICER AND CALIFORNIA DEPARTMENT OF HEALTH SERVICES

DATE OF REGISTRATION: MONTH DAY YEAR

FROM: BIRTH REGISTRAR OF

COUNTY OR CITY

WE HAVE REGISTERED THE FOLLOWING BIRTH WHICH OCCURRED OUT OF A LICENSE HEALTH FACILITY

NEWBORN'S NAME (as shown on the birth certificate): LAST FIRST SEX ☐ MALE ☐ FEMALE

MOTHER'S COMPLETE NAME: LAST FIRST MAIDEN

CURRENT ADDRESS: NUMBER STREET APARTMENT

CITY STATE ZIP CODE

BIRTH WEIGHT (grams) BIRTH DATE: MONTH DAY YEAR BIRTH HOUR (24 hour clock)

PARENT'S TELEPHONE NUMBER (indicate area code): — —

HAS A NEWBORN SCREENING TEST BEEN DONE? ☐ YES ☐ NO

IF YES, WHERE WAS THE TEST DONE?

DATE OF TEST: MONTH DAY YEAR

NEWBORN'S PRIMARY CARE PROVIDER NAME: LAST FIRST

ADDRESS: NUMBER STREET SUITE

CITY STATE ZIP CODE

TELEPHONE NUMBER: — —

FILL BOX(es) IF APPROPRIATE: ☐ INFANT EXPIRED ☐ PARENTS REFUSED NEWBORN SCREENING TEST ☐ REFUSAL FORM SIGNED (ATTACH NBS-TR)

Please complete this form and mail **immediately** to:

WHITE–CA Department of Health Services, Newborn Screening Section, 850 Marina Bay Pkwy, F175, Richmond, CA 94804

YELLOW–Local Health Officer

PINK–Retain for your files

PLEASE SEE PRIVACY NOTIFICATION ON REVERSE

To reorder, request form NBS-OH from the Genetic Disease Branch, Newborn Screening Section, (510) 412-3950.

SAMPLE