

INSTRUCTIONS ON BACK OF FORM.  
PLEASE PRINT.

Label Area for  
Name of Newborn Screening Program  
and Laboratory Address

SN APHL 0000001



Patient Identification Number

Infant's Last Name

Infant's First Name

M M H D D H Y Y  
Date of Birth

H H M M  
Time of Birth (Military)

M M H D D H Y Y  
Date of Specimen Collection

H H M M  
Time of Collection (Military)

Birth Weight (g)

Sex  
M  F

Mother's Last Name

Mother's First Name

Mother's Address -- Street

Mother's Phone (home or cell)

City

State

Zip Code

Submitter's Identification

Submitter's Address -- Street

City

State

Zip Code

Physician's Name

Physician's Phone

HEARING RESULTS ARE ON BACK

PARENT'S COPY

FOLD BACK  
DURING DRYING.  
**DO NOT REMOVE  
THIS COVER FLAP.**  
IT IS FOR THE  
PROTECTION OF  
THE SPECIMEN  
AND THE SPECIMEN  
HANDLERS.

PLEASE MAKE  
SURE THAT THE  
BLOOD SPOTS ARE  
COMPLETELY DRY  
AND PROTECTIVE  
FLAP IS IN PLACE  
**BEFORE** SUBMITTING  
SPECIMEN.



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Ahlstrom 226  
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