☐ FIRST SPECIMEN ☐ REPEAT SPECIMEN

HOSPITAL OF BIRTH — CHECK IF SUBMITTER ☐

BABY'S MEDICAL RECORD NO. | HOSPITAL OF TRANSFER ☐

MOTHER'S NAME (LAST)

MOTHER'S NAME (FIRST) | MOTHER'S BIRTH DATE

STREET AND MAILING ADDRESS

CITY/TOWN | STATE | ZIP

HOME TEL. ( ) | CELL ( )

MOTHER'S MEDICAL HISTORY

THYROID DISEASE? ☐ YES — THYROID MEDS DURING PREGNANCY? ☐ YES ☐ NO

BABY'S DOCTOR — CHECK IF SUBMITTER ☐

STREET (P.O. BOX)

CITY/TOWN | STATE | ZIP

TELEPHONE ( )

IF HOME BIRTH, MIDWIFE'S NAME: — CHECK IF SUBMITTER ☐

SN VT471501

VERMONT 2018

ORIGINAL COPY

FOR LIST OF CONDITIONS SCREENED, CONTACT VT NEWBORN SCREENING PROGRAM AT (802) 951-5180

BABY'S NAME (LAST) (FIRST)

SEX ☐ M ☐ F | ☐ Single Birth | ☐ Multiple Birth ☐ A ☐ B ☐ C

BIRTH DATE mo / day / yr TIME: : ☐ AM ☐ PM

SPECIMEN DATE mo / day / yr TIME: : ☐ AM ☐ PM

GESTATIONAL AGE _____ weeks

BIRTH WEIGHT grams ____ ____ ____ ____ OR lbs/oz ____/____

CURRENT WEIGHT grams ____ ____ ____ ____ OR lbs/oz ____/____

IS THIS BABY LESS THAN 24 HOURS OLD? ☐ YES ☐ NO

HAS THIS BABY BEEN TRANSFUSED IN LAST 48 HOURS? ☐ YES ☐ NO

HAS BABY BEEN ON TPN IN LAST 72 HOURS? ☐ YES ☐ NO

IS BABY IN NICU? ☐ YES ☐ NO

SAMPLE COLLECTED IN:

☐ HOSPITAL ☐ DR.'S OFFICE ☐ HOME ☐ OTHER _____

COMMENTS:

THIS AREA FOR SCREENING LABORATORY USE ONLY

SN VT471501 SN VT471501 SN VT471501

FOLD BACK DURING DRYING BUT **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