Newborn Screening - Michigan Department of Community Health
Bureau of Laboratories P.O. Box 30689 3350 N. MLK Jr. Blvd. Lansing MI 48909
DCH-1153 L-XXXXXXX Print Firmly with Black Pen

BABY

LAST NAME | FIRST NAME | GENDER ○ MALE ○ FEMALE

BIRTH DATE M M D D Y Y | BIRTH TIME (Military) H H M M | BIRTH WT. (gms) | WKS GESTATION

○ SINGLE BIRTH ○ MULTIPLE BIRTH → BIRTH ORDER ○ A ○ B ○ C ○ D

ANTIBIOTICS? ○ NO ○ YES

SPECIMEN DATE M M D D Y Y | COLLECTION TIME (Military) H H M M | Collected By: (initials) _____

NICU/ SPECIAL CARE? ○ NO ○ NICU ○ SP CARE

ANY RBC TRANFUSION? ○ NO ○ YES DATE → M M D D Y Y

MEDICAL RECORD #

ANY TPN FEEDING? ○ NO ○ YES

○ HISPANIC ○ NON-HISPANIC

○ WHITE ○ AMERICAN INDIAN ○ ARAB DESCENT ○ BLACK ○ ASIAN/PACIFIC ISLAND ○ MULTI-RACIAL

MOTHER

LAST NAME | FIRST NAME

MOM/BABY STEROID Tx? ○ NO ○ YES

ADDRESS | PHONE

CITY | STATE | ZIP | SOCIAL SECURITY NUMBER

MEDICAL RECORD # | BIRTH DATE M M D D Y Y

HEPATITIS B SURFACE ANTIGEN (HBsAg) TEST DATE M M D D Y Y RESULT ○ POSITIVE ○ NEGATIVE

PHYSICIAN

LAST NAME | FIRST NAME

PHONE | FAX

FIRST SAMPLE

SUBMITTER

SUBMITTER NAME | HOSPITAL CODE (if applicable) 0 0

ADDRESS | PHONE

CITY | STATE | ZIP

MDCH use only

BIRTH HOSPITAL (if different from submitter)

MDCH USE ONLY

MI Dept. of Comm. Health
Card Expires 03/09
By Authority of Act 368
MCLA 333.5431

1234567