NEWBORN SCREENING CARD REPLACEMENT FORM

Date: _____

FACILITY NAME: _____

ATTN: (DEPT) _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CONTACT NAME: _____ TELEPHONE # _____

NUMBER OF CARDS RETURNED FOR REPLACEMENT: _____

I.D. NUMBERS ON THE CARDS RETURNED:

- This form should be filled out completely.
- Attach **WHITE FACE SHEET(S) ONLY.**
- If there is blood on the white face sheet, place it in a biohazard bag.
- **DO NOT send card replacement requests to the NBS Laboratory.**
- **DO NOT USE COURIER ENVELOPES** for card replacement requests.

SEND FACE SHEET(S) OF CARD(S) TO BE REPLACED AND THIS FORM TO:

Michigan Department of Health and Human Services
Attn: Newborn Screening
333 S. Grand Ave., 2nd floor
PO Box 30195
Lansing, Michigan 48909

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