



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:

Table with 5 columns and 5 rows for recording I.D. numbers.

- This form should be filled out completely and mailed with the WHITE FACE SHEET(S) ONLY of the card(s) intended for replacement to the address below. It is not necessary to include the remaining portions of the kit.
• To ensure a quicker turnaround time, send 10 face sheets or less.
• If there is blood on the white face sheet, place and submit in a biohazard bag.
• DO NOT send card replacement requests to the NBS Laboratory. Failure to send your request to the address below may result in no credit being issued. (Please note: Courier envelopes are sent to the lab. DO NOT USE COURIER ENVELOPES for card replacements.)

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 Avenue,
PO Box 30195
Lansing, Michigan 48909