



Every time you fill out a newborn screening form, you hold a baby's life in your hands.



BABY	LAST NAME		FIRST NAME		SEX <input type="radio"/> MALE <input type="radio"/> FEMALE <input type="radio"/> AMBIGUOUS
	BIRTH DATE	BIRTH TIME (Military)	BIRTH WEIGHT(grams)	WKS GESTATION	SINGLE BIRTH <input type="radio"/> MULTIPLE BIRTH → <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C <input type="radio"/> D
	COLLECTION DATE	COLLECTION TIME	COLLECTED BY:	NICU or SPECIAL CARE? <input type="radio"/> NO <input type="radio"/> NICU <input type="radio"/> SP CARE	ANY RBC TRANSFUSION? <input type="radio"/> NO <input type="radio"/> YES →
MOTHER	IF NOT BIRTH PARENT: <input type="radio"/> ADOPTIVE PARENT <input type="radio"/> FOSTER PARENT <input type="radio"/> ADOPTION AGENCY		LAST NAME		FIRST NAME
	ADDRESS		CITY		STATE ZIP
	MEDICAL RECORD #		BIRTH DATE		HEPATITIS B SURFACE ANTIGEN (HBsAg) TEST DATE RESULT <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE
SUBMITTER	LAST NAME		FIRST NAME		FIRST SAMPLE
	PHONE		FAX		
	SUBMITTER NAME		PHONE		
ADDRESS		CITY		STATE ZIP	HOSPITAL CODE (if applicable) 00
BIRTH HOSPITAL (if different from submitter)		MDHHS USE ONLY		NOTES (ex: transfer, family history of NBS disorder, phototherapy)	



DHHS USE ONLY

Do not affix stickers here.

EXPIRES: 2026-10-31

Check expiration date before specimen collection.



NBS Kit Number

Baby's Name: If first name has not been decided, use "boy" or "girl".

Sex: Vital in alerting lab of ambiguous genitalia.

Birth date/time + Collection date/time: Record in military time. Exact age of infant (in hours) and time of collection is critical for validity of test results.

Birth weight: Record in grams. Accuracy is critical for lab cutoff values.

Weeks gestation: Record weeks gestation at time of birth.

Single/Multiple birth/Birth order: Birth order is vital for linking results.

Antibiotics: Mark "yes" if the infant is currently receiving antibiotics or has received antibiotics postnatally within 48 hours before specimen collection.

Meconium Ileus: If meconium ileus is present, select yes. If not, select no.

NICU or Special Care (SCN): Indicate if infant is in NICU or SCU at time of collection. If neither, select no.

RBC Transfusion: Indicate "yes" if the newborn was ever transfused with red blood cells prior to specimen collection, including in utero. Record the most recent transfusion date and start time (in military time).

Medical Record Number: Record infant's hospital MRN.

Ethnicity/Race: Record **both** ethnicity and race. If father's race is unknown, use mother's ethnicity and race.

Type of collection: Heel stick is the preferred method. If another method used, indicate method. Flush type is flush used prior to collection, if any.

Other feeding: Check all that apply. Formula: Select milk-based or soy.

TPN: Select "yes" if infant is receiving TPN at the time of specimen collection or has received TPN within 24 hours of collection.

Mother's Name: Record name as it will appear on birth certificate. If infant will not be released into care of mother, mark the appropriate circle. Provide contact information for the adoptive/foster parent or adoption agency in place of the mother's information.

Mother's Contact info: Record accurate address and phone number. This is critical to locate newborns in need of clinical evaluation or retesting.

Mother's Medical Record: Record mother's hospital MRN.

Mother's Date of Birth: Record accurately for linking of records.

Hep B Surface Antigen: Record date of mother's test and result. Positive results should be faxed to MDHHS Perinatal Hep B Prevention Program at 517-763-0470.

Provider contact information: Verify and record accurate PCP contact information. If infant is expected to be in NICU for >1 week, record neonatologist and NICU contact info in the provider area. This is critical information, as the recorded provider will be contacted with abnormal results or need to retest. **DO NOT LEAVE BLANK.**

Submitter contact information: Record accurate submitter contact info. Pre-printed hospital labels may be used, but must contain all requested info, including hospital code.

Birth hospital: Record name of birth hospital or home birth, if different from submitter.

Notes: Use space to notify NBS Program of any additional information, such as family history of disorder, transfers, safe surrender, etc.

MDHHS Use Only – Please do not write or place stickers in this spot.

Ensure demographic portion of NBS card is filled out clearly and correctly. If an error occurs, put a single strikeout line through incorrect information, clearly write correct information next to it, and make a notation in notes field attesting corrections are accurate. If multiple errors occur, use a new screening card. The original screening card can be replaced for free. Instructions for replacement are at [MDHHS - Newborn Screening - Resources for Hospitals and Health Professionals \(michigan.gov\)](#) in the forms section.