NEWBORN SCREENING CARD REPLACEMENT FORM

Date: ______________________________

Facility Name: ____

Attention/Department:____

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 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.**
- 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.** Failure to send your request to the address below may result in no replacement card being issued. Please note: Courier envelopes are for blood spot specimens.**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

Rev. 2/16/2022