10534640
6222306

Iowa Neonatal Metabolic Screening Form

☐ First Screen ☐ Repeat Screen ☐ Check if infant is in NICU

Collector's Initials

Infant's Chart Number

Feeding Method

☐ Formula
☐ Breast
☐ NPO
☐ Parenteral Nutrition
☐ Other

_____

BABY

Infant's Last Name

Birth Date (Month / Day / Year)

Birth Time (24 hour clock)

Infant's First Name

Sex ☐ M ☐ F

Collection Date (Month / Day / Year)

Collection Time (24 hour clock)

Multiple Births ☐ Yes ☐ No

Birth Order 1, 2, 3, etc.

Current Weight (GMS)

Transfusion ANY blood products ☐ Yes ☐ No

If yes, date of transfusion (Month / Day / Year)

Gestational Age

MOTHER

Mother's Last Name

Mother's Birth Date (Month / Day / Year)

Mother's First Name

Mother's Zip Code

Mother's Phone Number or Contact's Phone Number
Area Code / Number

SUBMITTING FACILITY

Submitting Facility's Name

Facility Number

Submitting Facility's Phone Number
Area Code / Number

Submitting Facility's Address
Street / City / State / Zip Code

ATTENDING HEALTH CARE PROVIDER

Attending Health Care Provider

Attending Health Care Provider Phone Number
Area Code / Number

DO NOT WRITE IN THIS SPACE

INMSP DATA ENTRY COPY FOR NORTH DAKOTA

0 0 3 2 4 8 9 2

ATTN. SUBMITTER

FILL OUT FORM.

REMOVE (THIS COPY ONLY) AND RETAIN FOR YOUR RECORDS BEFORE APPLYING THE BLOOD SPOTS.

Whatman 903® LOT # W-041
Expiration Date - 02/08