SEE DIRECTIONS ON BACK. PLEASE PRINT CLEARLY OR USE PREPRINTED LABELS.

KY EXPANDED NEWBORN SCREENING PROGRAM

Cabinet For Health & Family Services - Laboratory Services
PO Box 2010 Frankfort, KY 40602
100 Sower Blvd, Suite 204 Frankfort, KY 40601
Tel. # (502) 564-4446 ext. 4433 Fax # (502) 564-2905 or 2413

KY STATE LAB USE ONLY

MOTHER'S INFORMATION

First Name ______ Last Name ______
Social Security Number ______ County of Residence ______
Street Address (PO Box) ______
City ______ State ______ Zip ______
Mother's Phone Number ______ Alternate Phone Number ______ Mother's Email Address ______

CHILD'S INFORMATION

First Name ______ Last Name ______
DOB: __ / __ / __ Time: __ : __ (Military) ☐ Male ☐ Female Race ______
Gestational Age ______ ☐ Single Birth ☐ Multiple Birth ☐ (A, B, C, etc.) Birth Weight ______ Current Weight ______
☐ Antibiotics ☐ Meconium Ileus ☐ Transfused - Last Date: __ / __ / __
☐ TPN/NPO ☐ Breast ☐ Bottle Date of First Feeding: __ / __ / __
Medical Record Number ______ ☐ Baby still in NICU ☐ Home Birth

SUBMITTER INFORMATION

Submitter's ID: ______ Phone #: ______
Facility Name: ______
Address: ______

SPECIMEN COLLECTION

Collection Facility: ☐ Hospital ☐ Dr.'s Office ☐ Midwife ☐ Health Dept. ☐ Other: ______
Specimen Type: ☐ Initial Screen
Repeat: ☐ Bio ☐ CAH ☐ T4/TSH ☐ CF ☐ Galt ☐ Hemo ☐ AA, FAO, OA ☐ SCID ☐ LSD ☐ All Tests
Was Previous Specimen Unsatisfactory or Sub-optimal? ☐ Yes ☐ No
Date Collected: __ / __ / __ Time: __ : __ (Military)
Comments: ______ Collector: ______

PHYSICIAN INFORMATION

License #: ______ Phone #: ______
Name: ______
Street Address (PO Box): ______
City: ______ State: ______ Zip Code: ______

AFFIX MEDICAL LABEL(S) HERE

INFORMATION MUST BE PROTECTED ACCORDING TO HIPAA GUIDELINES

GOOD THROUGH 2019-09-30
LOT 105616 / 316136

SN 16195692

SN 16195692

SN 16195692

SN 16195692