MEDICAID **Newborn Screening** CHIP/CHARITY

TEXAS DEPARTMENT OF STATE HEALTH SERVICES Laboratory Services Section CLIA#45D0660644
FORM NBS 3 **Expires 09/01/2018.** Telephone # (800) 252-8023 ext. 7318

Please read the instructions on the back of this form before starting. USE BLACK INK. PRINT INFORMATION COMPLETELY, ACCURATELY, & LEGIBLY IN BLOCK CAPITAL LETTERS.

DSHS Lab No. For Texas DSHS Use Only

MOTHER INFORMATION

Mother's Last Name | Mother's First Name

Maiden Name | Social Security #

Mother's Birth Date M M D D Y Y | Medicaid Eligible (1-Yes, 2=No) | Medicaid No.

Street Address | Apt No.

City | Zip Code | State

Best Phone Number to Reach Mother | Newborn's Father's Last Name

BABY'S PRIMARY CARE PHYSICIAN INFORMATION

Physician Name (Last, First) | NPI No.

Street Address | Apt No.

City | Zip Code | State

Phone No. | Fax No.

SN TX 16-0340001 3

DSHS Copy

SPECIMEN REJECTED if NO Date of Collection or NO Newborn's Last Name is provided.

NEWBORN INFORMATION

Newborn's Last Name | First Name/Twin A or B

Medical Record No. | Birth Order (1-9), if Multiple | Birth - Date M M D D Y Y | Military Time

Birthweight (grams) | Previous Specimen Serial Number | Collection - Date M M D D Y Y | Military Time

Sex	Ethnicity	Status	Baby's Age at Time of Collection / Test
1. Male 2. Female	1. White 2. Af. Amer. 3. Hispanic 4. Asian 5. Am. Indian 6. Other	0. Normal 1. Sick/Premature 2. On Medications 3. Transfused 4. Both 1 & 2 5. Both 1 & 3 6. Both 2 & 3 7. All 1-3	1. Less than 7 days old 2. 7 days or older 3. Previous Abnormal: Enter Texas DSHS Laboratory No.

Feed: 1. Breastmilk only; 2. Formula only; 3. TPN ± Milk; 4. Breastmilk & Formula

SN 16-0340001

SUBMITTER INFORMATION

NBS ID No. _____ / NPI No. _____

Name _____

Address _____ Affix Mailing Label or Print Return Address

City _____ TX Zip Code _____

Check to verify parent information & decision form distributed ☐