MONTANA DPHHS NEWBORN SCREENING
Public Health Laboratory
P.O. Box 4369, Helena, MT 59604-4369

SN

363994

PLEASE LEAVE BLANK

Do Not Write in This Space

Baby's Last Name	B A B Y ' S L A S T N A M E
Baby's First Name	B A B Y ' S F I R S T N A M E
Baby's ID Number	M E D I C A L R E C O R D N O. Gender ☐ M ☐ F
Mother's Last Name	B I R T H M O T H E R ' S L A S T N A M E
Mother's First Name	B I R T H M O T H E R ' S F I R S T N A M E
Baby's Provider	L A S T N A M E , F I R S T N A M E
Medicaid ID Number	
Provider NPI #	

MTPHL 0715

Submitting Facility:

**WE WILL APPLY A STICKER HERE
WITH YOUR FACILITY INFORMATION**

RACE OF BABY (Check all that apply)
☐ White ☐ Black ☐ Native Amer. ☐ Asian ☐ Other ☐ Unk
ETHNICITY OF BABY (Check only one)
☐ Non-Hispanic ☐ Hispanic ☐ Unknown

SPECIMEN ☐ 1st ☐ Repeat

BIRTH DATE AND TIME   TIME (MILITARY)
M O / D A Y / Y E A R   2 4 - H R   C L O C K

SPECIMEN COLLECTION DATE AND TIME   TIME (MILITARY)
M O / D A Y / Y E A R   2 4 - H R   C L O C K

☐ SINGLE BIRTH
IF MULTIPLE ☐ A ☐ B ☐ ____

BIRTH WEIGHT (grams)
G R A M S

HAS THE BABY RECEIVED A RBC TRANSFUSION? ☐ Y ☐ N
DATE OF TRANSFUSION
OTHER CONSIDERATIONS ☐ Adopted ☐
IS THE BABY IN THE NICU? ☐ Y ☐ N

NICU INFANT INFORMATION
FEEDING METHOD
☐ TPN ☐ Breast ☐ Formula, Soy ☐ Formula, Lactose
IS MOTHER OR INFANT ON STEROIDS? ☐ Y ☐ N
IS MOTHER OR INFANT ON ANTIBIOTICS? ☐ Y ☐ N

GESTATIONAL AGE
|___|___| (weeks)

Baby's Last Name: If the last name has changed since the baby was born, please enter it here. We are required to enter what is on the requisition, not what is on the patient manifest.

Baby's First Name: If the newborn does not yet have a name, we will use the sex and mother's first name (e.g. BoyEmily or GirlElizabeth). In the case of multiples, we will use birth order, sex, and mother's first name (e.g. ABoyEmily or BGirlElizabeth). This is to avoid confusion if we have a baby with the same sex, same date of birth, and same last name.

Baby's ID Number: This should be a unique number assigned to the baby, for example a medical record number. This unique number helps to avoid having multiple records in our laboratory information system.

Gender: Please check male or female. In some cases, it is difficult to discern by the newborn's first name.

Mother's Last Name: This should be the birth mother's last name, regardless if this is a surrogacy or adoption situation. If the birth mother's name is not known, please indicate that on the requisition.

Mother's First Name: This should be the birth mother's first name, regardless if this is a surrogacy or adoption situation. If the birth mother's name is not known, please indicate that on the requisition.

Baby's Provider: Please provide the name of the pediatrician who attended or who will take over the baby's care after discharge. Please enter the last name AND the first name. **This information is required for NBS follow-up, if needed.**

Medicaid ID Number: As applicable.

Provider NPI Number: If known. This information ensures that we select the correct provider for the baby's care.

Race of Baby: Check all that apply, if known. If nothing indicated, our laboratory information system will default to unknown.

Ethnicity of Baby: Check only one, if known. If nothing indicated, our laboratory information system will default to unknown.

Specimen: Please check first if this is the first screen drawn on the newborn. Please check repeat if this is a subsequent screen drawn on the newborn.

Birth Date and Time: Please enter the two-digit month, two-digit date, and four-digit year. The time should be on a 24-hour scale.

Collection Date and Time: Please enter the two-digit month, two-digit date, and four-digit year. The time should be on a 24-hour scale. This is essential information since Montana rule specifies timing of collection of samples.

Birth Order: If this is a single birth, please mark single. In case of multiples, please indicate the birth order for the newborn.

Birth Weight: Please enter the birth weight **in grams**. This is the **newborn's weight at birth**, not the weight at the time the sample was drawn.

If the baby has received a **blood transfusion**, please mark yes, and indicate the date. If nothing is marked, the answer will default to no.

Please indicate if the newborn is in the **NICU**. If nothing is marked, the answer will default to no.

NICU Newborn Information: This information is helpful to capture on all newborns, not just NICU newborns. **Please provide all information, since it might be used in screening result evaluation.**

Gestational Age: This is the week of gestation when the baby was born, not what would be the gestation at the time the sample was drawn.

Feeding Method: Please indicate the feeding method, if known, at the time of collection. **It is especially important to note Total Parenteral Nutrition (TPN) for screening result evaluation.**

Is Mother or Infant on Steroids? Antibiotics? Check yes or no. **Some medications can affect screening results.**