Hospital Report of Newborn Metabolic Screening Specimen Not Obtained

State Department of Health
Newborn Metabolic Screening Program
741 Sunset Avenue, Honolulu, HI 96816
Phone: (808) 733-9069 Fax: (808) 733-9071

HOSPITAL REPORT OF NEWBORN METABOLIC SCREENING SPECIMEN NOT OBTAINED

Please TYPE or PRINT and send copy to DOH/NBMSP within 48 hours of transfer/discharge/death.

Name of Hospital: _____ Infant's MR#_____

Name of Newborn (**Last name first**): _____ Male Female GA: _____

Mother's Legal Name (**Last name first**): _____ DOB: _____

Address (Number and street): _____

City: _____ Island: _____ Zip_____ Phone # _____

Birthdate: _____/_____/_____ Birth Hour: _____Birthweight: _____ lbs ____oz or _____ grams

Name of Infant's Physician: _____ Phone: _____

The above newborn was discharged/transferred on _____/_____/_____without Newborn Screening Tests performed because (check one):

☐ Parent(s) refused testing. (Fill out refusal form. Have parent(s) sign. Attach original to infant's medical record and send copy with this form to DOH/NBMSP.)

☐ Transferred to the following hospital:

Name of receiving hospital: _____City: _____State: _____Zip: _____

☐ Expired Date_____/_____/_____

Diagnosis_____

☐ Other (specifiy)_____

Name of person completing form _____

Date_____/_____/_____

Note: The physician and hospital are responsible for assuring that each infant born or transferred under their care is satisfactorily tested. Completion of this form does not transfer this responsibility to the State of Hawaii/Newborn Metabolic Screening Program.

COPIES TO:

1. Hospital originating this form (infant's medical record)
2. Department of Health/Newborn Metabolic Screening Program
   741 Sunset Avenue, Honolulu, HI 96816 or Fax 733-9071
3. Hospital receiving transferred infant (if applicable)

Updated 08/19