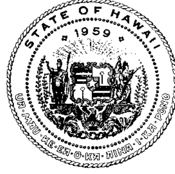

Department of Health
Children with Special Health Needs Branch
741 Sunset Avenue
Honolulu, HI 96816

Newborn Metabolic Screening Program
Ph: (808) 733-9069 Fax: (808) 733-9071

Newborn Hearing Screening Program
Ph: (808) 733-9052 Fax: (808) 733-9068

NOTIFICATION OF BIRTH

Infant's Name: ____ Gender: M ____ F____
Last First

Date of Birth: _________________ Time: ____________ Weight: _________GA: ________

Mother's Name: __________________________________Mother's Birthdate: ____________________

Father's Name: ______________________________________

Mailing Address: ____

____

Home Address: ____

____

Parents' Contact Phone Number: ________________ Alternate Phone Number _________________

Name of Birth Attendant: _______________________________ Contact Phone: ________________

Birth Facility: Home ______ Birthing Center (name): ________________________

Name of Infant's Physician: ______________________________ Contact Phone: ________________

Form completed by: ___________________________________ Date: _________________

Newborn Screening done? Yes ___ Date Tested: ______________
No ___ If No, refusal form completed? Yes ____ No ____
Fax or mail this form and refusal form to Newborn Metabolic Screening Program; fax (808) 733-9071

Newborn Hearing Screening done? Yes ___ No ___ If No, refusal form completed? Yes ____ No ____
Fax the refusal form to Newborn Hearing Screening Program; fax (808) 594-0015

9/2020