



STATE OF HAWAI'I
 DEPARTMENT OF HEALTH
 KA 'OIHANA OLAKINO
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
 741 SUNSET AVENUE, HONOLULU, HI 96816

Newborn METABOLIC Screening Program
 Phone (808)733-9069 | Fax (808)733-9071 | eFax (808)207-0067*

Newborn HEARING Screening Program
 Phone (808)733-9052 | Fax (808)733-9068*

Notification Of Birth Form

Name of Newborn (LAST, FIRST)		Date of Birth		Time of Birth	
Gender <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	Gestational Age (Weeks)	Birth Weight			
		LB	OZ	Grams	
Name of Mother (LAST, First)		Mother's Date of Birth			
Name of Father (LAST, First)		Mother / Father Phone #		Alternate Phone #	
Mailing Address		City / State / Zip			
Home Address		City / State / Zip			

HOME BIRTH		FACILITY BIRTH	
Name of Birth Attendant	Attendant Phone #	Name of Birth Facility	Facility Phone #
Physician of Newborn		Physician's Phone #	

Newborn METABOLIC screening completed?		Newborn HEARING screening completed?	
YES <input type="checkbox"/> NO <input type="checkbox"/>	Date of METABOLIC screen	YES <input type="checkbox"/> NO <input type="checkbox"/>	Date of HEARING screen
Refusal form completed? <i>fax/mail refusal form to METABOLIC program*</i>		Refusal form completed? <i>fax/mail refusal form to HEARING program*</i>	
YES <input type="checkbox"/> NO <input type="checkbox"/>	Date REFUSAL signed	YES <input type="checkbox"/> NO <input type="checkbox"/>	Date REFUSAL signed

Name of Person Completing Form (PRINT)	Name of Person Completing Form (SIGNATURE)	Date
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