STATE OF HAWAIʻI
DEPARTMENT OF HEALTH
KA ʻOIHANA 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**

FEMALE **MALE**
Gender

weeks
Gestational Age

lbs oz grams
Birthweight

Name of Mother (LAST, First)

Mother 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

Name of Birth Attendant **Attendant Phone #**

FACILITY BIRTH

Name of Birth Facility **Facility Phone #**

Physician of Newborn

Physician's Phone #

Newborn METABOLIC screening completed?

YES **NO**
Date of METABOLIC screen

Refusal form completed?
*fax/mail form to METABOLIC program**

YES **NO**
Date REFUSAL signed

Newborn HEARING screening completed?

YES **NO**
Date of HEARING screen

Refusal form completed?
*fax/mail form to HEARING program**

YES **NO**
Date REFUSAL signed

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