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

Specimen Not Obtained Form

Submit within 48 hours of death/discharge/transfer

Hospital / Place of Birth

Medical Record Number

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)

Address of Mother

Phone #

Island

City / State / Zip

Physician of Newborn

Physician's Phone #

The above newborn was discharged/transferred on, _____ without Newborn Screening test performed due to the following (select one):
Discharge/Transfer Date

☐ **REFUSAL** **Parent completed and signed Newborn Metabolic Screening Test Refusal Form* ☐ YES ☐ NO

☐ **EXPIRED**
Expired Date
Diagnosis

☐ **TRANSFER**
Name of Hospital
Address of Hospital
City / State / Zip

☐ **OTHER**
Specify

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 Hawai'i / Newborn Metabolic Screening Program.

Name of Person Completing Form (PRINT)

Name of Person Completing Form (SIGNATURE)

Date

COPIES TO: 1) Hospital **ORIGINATING** this form (include **ORIGINAL** of Test Refusal Form if applicable)
2) State of Hawai'i Newborn Metabolic Screening Program (include **COPY** of Test Refusal Form if applicable)
3) Hospital **RECEIVING** transferred infant (if applicable)