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)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) _____ Mother's Date of Birth _____ Mother's Phone # _____

Address of Mother _____ City / State / Zip _____

Physician of Newborn _____ Physician's Phone # _____

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

☐ **REFUSAL** **Parent completed and signed Newborn Metabolic Screening Test Refusal Form* ☐ **YES (faxed)**

☐ **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)