

**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)207-0067

**Hospital Monthly Report Form**

Submit no later than 30 days after the end of the month

1. Month \_\_\_\_\_ Year \_\_\_\_\_ 2. Hospital \_\_\_\_\_

<b>3.</b>	Number of <b>LIVE BIRTHS</b> at your hospital: _____
<b>4.</b>	Number of newborns <b>TRANSFERRED</b> TO your hospital <b>WITHOUT</b> a screening: _____
<b>5.</b>	Total number of newborn screenings <b>NOT COMPLETED</b> : _____
<b>6.</b>	Total number of newborn screenings <b>COMPLETED</b> : _____

STATUS TYPE	STATUS DETAILS
<i>Expired</i>	- Specimen Not Obtained Form - Medical records with expired status
Other	AMA, lethal conditions, missing result, unacceptable specimen
<i>Refusal</i>	- Specimen Not Obtained Form - Test Refusal Form
Transfer	Hospital newborn transferred to

**7. Complete information below for newborn screenings NOT COMPLETED:**

ACC #	NEWBORN NAME (LAST)	MOB NAME (LAST, First)	SEX	MRN	BIRTHDATE	DISCHARGE	PROVIDER	STATUS TYPE	STATUS DETAILS
<small>NBS STAFF USE ONLY</small>	ALOHA	ALOHA, Aunty	F	000000000	01/01/2023	01/02/2023	K Kupuna, MD	transfer	KMC NICU

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