NEWBORN SCREENING LABORATORY
CHANGE OF INFORMATION REQUEST

This form is to be utilized by hospitals, midwives and other dried blood spot specimen submitters who need to update or correct information previously submitted to the NBS laboratory on the NBS card.

DATE: _____

HOSPITAL: _____

INFANT'S NAME: _____

DATE OF BIRTH: _____

MOTHER'S NAME: _____
(Please include first and last names)

REQUISITION #: _____

INFORMATION NEEDING TO BE CORRECTED:

If corrected information pertains to dates and/or times, indicate both in military time. Be specific about changes.

Is a corrected report is needed? ☐ **YES** ☐ **NO**

Changes authorized by: _____

Fax changes to:

Newborn Screening Lab 351
West 10th Street, Suite 350
Indianapolis, IN 46202
FAX: 317-321-2495
PHONE: 317-278-3245

Or mail to:

ATTN: Records Management
I.U. Newborn Screening
Laboratory PO Box 770
Indianapolis, IN 46206

PLEASE NOTE: ALL REQUESTS TO CHANGE INFORMATION SHOULD BE ACCOMPANIED BY THIS FORM.