

REQUEST FOR ASSISTANCE

Date:

County:

Please advise the parent(s) of the infant named below that a repeat test or initial test for newborn screening is necessary. This can be done at the hospital of birth or any other facility that has the heel-stick test kit. The hospital of birth is preferable as generally there is no additional charge for a rescreen. If the parents have any questions regarding this request, they may contact the Newborn Screening Program at the Indiana State Department of Health, (317) 233-1379.

Reason: Early Discharge _____
 Poor Sample _____
 Abnormal Result _____

<24 Hours Protein Intake _____
Transferred before Screen _____
Other: _____

Infant's Name:

D.O.B:

SEX:

Birth Institution:

Hospital Number:

Mother's Name:

Doctor's Name:

Address:

Doctor's Address:

Telephone:

Doctor's Phone:

Need Follow-up report returned by:

PHN Contacts:

Telephone Call: Yes _____ No _____ **Home Visit:** Yes _____ No _____

Date	Remarks
1) _____/_____/_____	_____
2) _____/_____/_____	_____
3) _____/_____/_____	_____
4) _____/_____/_____	_____
5) _____/_____/_____	_____

No Such Address: _____

Will Obtain Screen At: _____

Public Health Nurse: _____ **Telephone:** _____

USE BACK OF FORM FOR ADDITIONAL REMARKS

PLEASE RETURN THIS FORM TO:

**INDIANA STATE DEPARTMENT OF HEALTH
NEWBORN SCREENING PROGRAM / MCH
2 NORTH MERIDIAN
SUITE 700
INDIANAPOLIS, IN 46204**