

**Request for  
Administrative Forms and Information Materials  
Newborn Screening Program**

Date: \_\_\_\_\_

Hospital / Facility \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Contact Person \_\_\_\_\_

Phone # \_\_\_\_\_

Email \_\_\_\_\_

**Please send the requested items listed below to the address indicated above.**

<b>Items</b>	<b># of Copies</b>
Cystic Fibrosis (ISDH 9366)	
Monthly Summary Report	
Religious Waiver Form	
Newborn Screening Info. Parents Need to Know (Spanish) (ISDH 9372)	

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If you need assistance, please call 317-233-1254 or 888-815-0006

or

Mail or fax your request to:  
Indiana State Department of Health  
Newborn Screening Programs  
2 North Meridian Street, 7F  
Indianapolis, IN 46204  
Fax: (317) 234-2995

ISDH Office Use

Order received \_\_\_\_\_

Order filled \_\_\_\_\_