Pennsylvania
Department of Health

Division of Newborn Screening and Genetics Newborn Screening Status Report

Please complete the following information and fax the report to Pennsylvania Department of Health, Newborn Screening Follow-up Program (NSFP), at 717-724-6995

Submitter: _____ Sender's Name: _____

Baby's Name: (Boy) (Girl)_____

DOB:_____ Medical Record #: _____

Mom's Name: _____ Initial filter paper #: _____

If parent refusal or newborn expires, please include the following information:

Mom's DOB: _____ Phone number: _____

Mom's Address: _____

PCP Name: _____ PCP Phone number: _____

Change in Guardianship Upon Discharge

Guardian's Name: _____ Phone number: _____

Guardian's address: _____

☐ Repeat Filter Paper #: _____ Date of Collection: _____

☐ Transferred to: _____

☐ Expired date: _____

☐ Recent blood transfusion, date: _____

☐ CCHD screen: ☐ Pass ☐ Fail Date: _____ Time: _____

If not performed, check reason: ☐ Refused ☐ Prenatal Diagnosis of CCHD ☐ Birth weight < 1500 grams

☐ Postnatal echocardiogram performed ☐ Other: _____

If you require assistance in follow-up for this infant, please contact the NSFP staff at 717-783-8143.

Note: The information contained in this transmission is intended only for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this transmitted information is strictly prohibited and the contents should be returned to the sender immediately. In this regard, please notify the NSFP at the telephone number above immediately. Thank you.

REV January 2025