

Information requested on the top portion of the card must be completed for all screening requests.

**Reference ranges for newborn screening results are selected based upon the above demographic and clinical information. Failure to supply this essential information may result in specimen rejection.**

List a patient identifier such as a medical records, chart or lab accession number.

Patient's full name (first and last)

Sample Date, Collection Time, Date of Birth and Time of Birth are required for calculation of appropriate reference ranges.

Weeks gestation and Weight at the collection date

Was the patient at least 24 hours at the time of sample collection?

Check yes if gestation was less than 36 weeks

Was baby receiving Total Parenteral Nutrition at the time of sample collection?

If Checked Yes, enter the date of the transfusion and indicate if the transfusion was an exchange or a small volume.

Mother's Name


If a repeat specimen is requested by the IMD staff, please be sure to check the box labeled repeat screening. This will ensure that this specimen is screened at no charge.

- If the baby's name has changed since the original sample was submitted, please provide the original name as well as the current name to enable a more complete interpretation of the results.

Please have the ordering physician (or designee) sign the screening card. The signature of an individual designated by the physician to sign on his/her behalf will be accepted. A document indicating this approval must be on file at the physician's office and copy of the document must be available to Baylor upon request.

Please print, stamp or use a preprinted label in this area. Please include the name of the physician or contact in this area.

Provide the telephone number for the ordering physician. Provide the fax number for the ordering physician.



**METABOLIC DISEASE SCREENING**  
 Institute of Metabolic Disease Baylor University Medical Center  
 3812 Elm Street, Dallas, TX 75226  
 Phone: (214) 820-4533 Fax: (214) 820-4853

**IMD USE** 123600

Patient ID No. \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Sample Date: \_\_\_\_\_ Coll Time: \_\_\_\_\_  
 Sex:  Male  Female  
 Date of Birth: \_\_\_\_\_ Time of Birth: \_\_\_\_\_

**SUPPLEMENTAL NEWBORN SCREENING**

Weeks Gestation: \_\_\_\_\_ Weight: \_\_\_\_\_

At sample collection was patient 24 hrs old?  Y  N

Premature:  Y  N (check yes, if less than 36 weeks)

TPN?  Y  N (Total Parenteral Nutrition) Ethnicity/Race: \_\_\_\_\_

Transfused?  Y  N If Yes, Date: \_\_\_\_\_

Was transfusion:  Exchange or  Small Volume

Mother's Name: \_\_\_\_\_

**REPEAT SCREENING** (Requested by Institute of Metabolic Disease)

**OTHER TESTING PERFORMED BY INSTITUTE**  
 (Must be accompanied by a requisition for testing, call Institute to obtain)

Ordering Physician: \_\_\_\_\_  
(Physician signature)

Mail results to: \_\_\_\_\_  
(Please PRINT physician's or contact's name and mailing address)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

TEL: \_\_\_\_\_ FAX: \_\_\_\_\_

**IMPORTANT: COLLECTION INSTRUCTIONS ON BACK COVER**

**S&S<sup>®</sup> 903<sup>™</sup> LOT # W-011**  
L-6091703