REQUEST FOR OHIO NEWBORN SCREENING RESULTS

Mother's Name used at Delivery**:**

First: _____ Last: _____

Child's Date of Birth**: _____/_____/_____**

Child's Name:

First: _____ Last: _____

Birth Hospital _____KIT# _____

Please do NOT make requests before the infant is 10 days old.
Depending on work load, it may take a week to comply with requests.
Please do NOT make multiple requests for the same infant.

Request Date: ____/_____/_____

Requesting physician: _____

Contact Name (Print): _____

Practice Name: _____

Practice Address: _____

_____

Phone: _____ Fax: _____

I certify that this infant is receiving care at the above named medical practice

Signature: _____

Fax Requests to the Ohio Department of Health Newborn Screening Program at 614-644-4648