Ohio Newborn Screening Program
Letter of Correction

To request a corrected/amended report of an Ohio Newborn Screen (NBS) specimen, please complete this form and fax to ODH Newborn Screening lab at (614) 644-4648.

Kit Number: _____

Baby's Name: _____ _____ _____
First Name Last Name AKA

Mother's Name: _____ _____ _____
First Name Last Name AKA

Baby's Birth Date: _____ Birth Time: _____
(00:00 – 23:59)

Birth Hospital: _____

NBS Collection Date: _____ Collection Time: _____
(00:00 – 23:59)

Weight at Specimen Collection: _____
Specify Units

Information that needs to be corrected: _____
_____
_____
_____

Submitted by: _____ _____ _____
Person Completing Form Date Phone #

Facility/Office: _____