

# Georgia Newborn Screening Card

(Effective 7/1/2024)

IVD 2029-01-31 116265 / 30610008 LOT	SUBMITTER Submitting Healthcare Provider (Report and Invoice to): _____ Submitter Code _____ Submitting Facility's Address Street _____ City _____ County _____ State _____ ZIP Code _____	For GA State Lab Use Only Georgia Public Health Laboratory - Newborn Screening 1749 Clairmont Road, Decatur, GA 30033 Telephone: (404) 327-7900 Fax: (404) 327-7919 Form 3491 (Rev 05/2023)
	PEDIATRICIAN Pediatrician After Discharge Submitting Facility's Address Street _____ City _____ County _____ State _____ ZIP Code _____ Pediatrician's Mailing Address (Report Copy To) Street _____ City _____ County _____ State _____ ZIP Code _____	
BABY Reason for Test <input type="checkbox"/> 1 <sup>st</sup> Test <input type="checkbox"/> Routine Retest <input type="checkbox"/> Retest - Prior Unsatisfactory <input type="checkbox"/> Retest - Prior Abnormal <input type="checkbox"/> Parental Refusal	State Lab Use Only Unsat Code: _____	
	Chart Number/Medical Record Number _____ Hospital Lab Access No. _____ Birth Weight (Grams) _____ Collection Weight (Grams) _____ Gest. Age (Birth) (Weeks) _____ NICU <input type="checkbox"/> No <input type="checkbox"/> Yes Infant's Last Name _____ Birth Date (Month Day Year) _____ Birth Time (Military) _____ Adoption <input type="checkbox"/> No <input type="checkbox"/> Yes Infant's First Name _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown   Collection Date (Month Day Year) _____ Collection Time (Military) _____ Collected By (Initials) _____ <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth A B C D   Transfusion: <input type="checkbox"/> No <input type="checkbox"/> Yes   Date of Last _____ Protein Feed: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Both <input type="checkbox"/> Meconium ileus Parenteral Nutrition: <input type="checkbox"/> Yes <input type="checkbox"/> No   Formula Trade Name: _____ Infant's Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islands/ Native Hawaiian <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown   Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
MOTHER / GUARDIAN Mother / Guardian Last Name _____ Mother / Guardian Birth Date (Month Day Year) _____ Mother / Guardian or Contact's Number (Area Code) Number _____ Mother / Guardian First Name _____ Emergency Contact Number (Area Code) Number _____ Mother / Guardian Address _____ Street _____ City _____ County _____ State _____ Zip Code _____	HEARING   Final Screen Date: _____ Right Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail   Left Ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail   Screen Method <input type="checkbox"/> aABR <input type="checkbox"/> aOAE <input type="checkbox"/> aABR and aOAE Not Screened: <input type="checkbox"/> Delayed/WBN <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Delayed/NICU <input type="checkbox"/> Equipment Down <input type="checkbox"/> Transfer/Hospital	
	CCHD Results   Date: _____ Initial: Right Hand _____ Foot _____ Repeat: Right Hand _____ Foot _____ Final Outcome: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> ECHO Referred To: _____	
Revvity™ 226   Ahlstrom	SN GA0000000001 116265 / 30610008   Revvity™ 226   Ahlstrom   2029-01-31 LOT	
STATE LAB COPY		

