Form to Request Return of Residual Newborn Screening Specimen

Child’s Name: ____________________________________________________________

Child’s Date of Birth: ______________________________________________________

Parent or Guardian(s) Name: ________________________________________________

Name of Child’s Primary Health Care Provider: _________________________________

Manner of Obtaining the Residual Newborn Screening Specimen from the State Hygienic Laboratory in Ankeny, Iowa:  
☐ Registered Mail  
☐ Pick up at the Lab

Address for mailing residual newborn screening specimen:

________________________________________________________________________

☐ Photocopy of Government issued photo identification or notarized verification of identity is attached.

Parent or Guardian Signature ________________________________________________

Date ____________________________________________

You may return this signed form to the Iowa Newborn Screening Program at:

Email: Kimberly.Piper@idph.iowa.gov
Fax: 515-725-1760
Postal Service: Iowa Department of Public Health  
Center for Congenital and Inherited Disorders  
321 E. 12th Street  
Des Moines, IA 50319-0075

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