

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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