Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

Maternal NBS Follow-up

Department of Laboratories
4800 Sand Point Way NE FB.2.441
Seattle, WA 98105 (206) 987-2617
http://seattlechildrenslab.testcatalog.org/

Mother's Last Name	First	Middle	Birth Date **(Required)**	Legal Sex	Gender Identity

Outside Patient Number	Outside Specimen Number	Send Report To
Ordering Provider		Address
Phone Number	Diagnosis/ICD Code **(Required)**	Phone/Fax

REQUIRED SPECIMEN INFORMATION:

DATE COLLECTED: _____/_____/_____ ☐ Whole Blood ☐ Serum/Plasma ☐ Urine
TIME COLLECTED: _____:_____ AM/PM ☐ Skin ☐ Other_____

BLOOD

☐ **ACYLCARNITINE PROFILE, BLOOD**
☐ **AMINO ACID, QUANTITATIVE**
☐ **CARNITINE, PLASMA**
☐ **BIOTINIDASE**

URINE

☐ **ORGANIC ACIDS, URINE**

PATIENT INFORMATION

WHAT WAS THE ABNORMAL NEWBORN SCREEN ANALYTE?
☐ **C0**
☐ **C3**
☐ **C5-OH**
☐ **OTHER (PLEASE SPECIFY):** _____

CLINICAL HISTORY/REASON FOR SUBMITTING SAMPLE:

_____

_____

Please ship sample(s) to:
Seattle Children's Hospital
Attn: Lab Client Services
4800 Sand Point Way NE
Room FB.2.441
Seattle, WA 98105
Phone: (206) 987-2617

BILLING INFORMATION

PHYSICIAN NOTIFICATION: Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

BILLING NOTIFICATION: All samples will be billed to the referring institution unless complete billing and diagnosis information is provided on this form. Contact Seattle Children's Laboratory Client Services for additional assistance (206) 987-2617.

BILL TO:

☐ **Referring Institution (Preferred)** - Provide billing address or stamp institution's information.
(Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)

Billing Address:	Billing Contact Name:
Billing Contact Phone/Fax:	Billing Contact Email:

☐ **Primary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		Employer
Primary Care Physician		Phone Number
Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Secondary Insurance** (Attach copy of card.) ☐ **Medicaid** (Only Alaska, Idaho, Montana and Washington Medicaid are accepted.)

Insurance Company/Medical Coverage		
Claims Address		Phone Number
Policy Number		Group Number
Subscriber	Sex	Subscriber's DOB

☐ **Self Pay**- First, call Lab Client Services for pricing. Then, provide credit card information below or enclose a check with the sample.

Patient Address		
Guarantor Name	DOB	Relationship to Patient
Guarantor Address (if different from patient's)		
Guarantor Phone (if different from patient's)		
Name on Credit Card	Payment Amount	CVN
Card Number	Card Type	Expiration

Please visit our test catalog at http://seattlechildrenslab.testcatalog.org for testing information or call:

Lab Client Services (206) 987-2617 Biochemical Genetics Lab (206) 987-2216

Seattle Children's®
HOSPITAL • RESEARCH • FOUNDATION

Ship to: LABORATORY
4800 Sand Point Way NE, M/S: FB.2.441
SEATTLE, WA 98105