



NEWBORN SCREENING TEST QUESTIONNAIRE

Dear Parent (s):

Please assist us with the following information:

Newborn's Name: _____

Mother's Name: _____

Was a Newborn Screening Test Performed? Yes No

If yes, where was the test performed? _____

Date of test: _____

If no, please attach a copy of the refusal form signed (NBS-TR)

Does your newborn have a primary care physician? If so, please complete the following:

Provider's Name: _____

Address: _____

Telephone Number: _____

For further assistance, Please contact Victoria Cardenas at 951-358-5267.

06/15/2023