NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208
Phone: (518)473-7552 Fax: (518)474-0405
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FOLLOW-UP SUMMARY FORM

Dear Health Care Provider:

We have not yet received a repeat specimen for this newborn. Documentation of your follow-up activities is required, as specified in section 69.5 of Title 10 of the official compilation of Codes, Rules & Regulations of the State of New York. **Please summarize your efforts to obtain a repeat specimen**.

NEWBORN INFORMATION:

Name at Time of Birth: ______________________

Other Names (AKA): ______________________

Single Birth ☐ Twin A ☐ Twin B ☐ Other ____________

Mother's Name: ______________________

Date of Birth: ______________________

Gender: Male ☐ Female ☐

Hospital of Birth: ______________________

Medical Record #: ______________________

Status:

☐ In-patient at this facility
☐ Transferred to another facility, specify______________________
☐ Discharged to home

Calls to parent:
Dates called: ______________________

Letters to parent:
Dates sent: ______________________

Calls to primary care provider:
Dates called: ______________________

Letters to primary care provider:
Dates sent: ______________________

Comments: ______________________

We appreciate your efforts to obtain a repeat specimen. Thank you for your cooperation.

Sincerely,

Michele Caggana, Sc.D., FACMG
Director, Newborn Screening Program

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