National Institute of Mental Health & Neuro Sciences

(An Institute of National Importance)
Bangalore - 560029, India.

REQUEST FORM

Newborn Screening by Tandem Mass Spectrometry

Name: Referring Centre/Hospital:

Age/Sex:

Premature/ Full Term: Gestation age at delivery : ________ week _______day

Date of Birth: Birth weight:_________ (kg/gms)

Sample collection: Date _________ Time _________.

Father's Name: Mother's Name:

Patient's Address, Phone No. and E-mail id:

Type of feeding: **Breast/ Formula/Mixed**
(Please wait until feeding for >than 24 hours before collection)

Baby or Mother on Antibiotics/ Steroids / any other medications (Pl. Specify):

On Transfusion: **Yes/No** If Yes, when?_________ (Date)

Single/Multiple births (Pl. Specify):

Past history (Pl. Specify):

Family history of similar illness: **Yes/No** Parental consanguinity: **Yes/No**
If Yes, Pl. Specify: **(1°/2 °/3 °)**

Any symptoms present? (Pl.Specify):

Date:

Signature of the Doctor

Name of the Doctor:

Phone Number:

E-mail id: