Complete and print.

Reset Form

MAYO CLINIC LABORATORIES

Request for Original Newborn Screening Card

Name of State Newborn Screening Laboratory*	Date Today (mm-dd-yyyy)
Address (Street, City, State, ZIP Code)	Fax

Dear Dr. _____:
Director of State Newborn Screening Laboratory

I/We hereby authorize you to send the original newborn screening card of our child,

_____ _____
Name (Last, First Middle) Birth Date (mm-dd-yyyy)

Send to: Mayo Clinic – Biochemical Genetics Laboratory
Attn: Dr. Dietrich Matern, MD, Hilton 330
200 First Street SW
Rochester MN 55905

Include a copy of this letter with the sample.

Our child was born at _____
Hospital Name or Other

in _____ , _____.
City State

Birth parent(s) name(s) (Last, First Middle) _____

Sincerely,

▶ _____ _____
Signature Required
Parent or Legal Guardian Signature Relationship to Child

Attention Mayo Clinic Biochemical Genetics Laboratory:

Contact Dr. _____
Provider or Medical Examiner (Last, First Middle)

for clinical information about our child. This provider or medical examiner can be contacted at:

_____ _____
Phone Fax

We understand that results will be reported to this provider or medical examiner.

*Some state newborn screening labs require their own form for release of dried blood spots.

Print