Complete, print and submit.

MAYO CLINIC LABORATORIES

Request for Original Newborn Screening Card

Reset Form

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 daughter or son,

_____ Birth Date _____
Name *(Last, First, Middle)* *(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 daughter or son was born on _____, at _____
(mm-dd-yyyy) Hospital Name or Other

in _____, _____.
City State

Sincerely,

_____ or _____
Mother's Signature Father's Signature

Attention Mayo Clinic Biochemical Genetics Laboratory:

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

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

Phone _____ Fax _____

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

Print