IOWA | Health and Human Services
Public Health

FORM TO REQUEST RETURN OF RESIDUAL NEWBORN SCREENING SPECIMEN

Child's Name at Birth: _____

Child's Date of Birth: _____

Parent or Guardian Name: _____

Name of Child's Primary Health Care Provider:

_____

Address for mailing the residual newborn screening specimen (specimen will be sent from the State Hygienic Laboratory via Registered Mail):

_____

_____

Please check:

☐ Photocopy of government issued photo identification or notarized verification of identity is attached.

Parent or Guardian Signature: _____

Date: _____

Please return this signed form to the Iowa Newborn Screening Program at:

Email: Kimberly.NoblePiper@hhs.iowa.gov

Fax: 515-242-6013

Postal Service: Iowa Department of Health and Human Services
Center for Congenital and Inherited Disorders
321 E. 12th Street
Des Moines, IA 50319-0075

If you need help completing this form or want to request an accommodation, contact access@hhs.iowa.gov. Business hours are Monday-Friday, 8:00 am – 4:30 pm.

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