NEW YORK STATE DEPARTMENT OF HEALTH
Wadsworth Center

Newborn Screening Program
Hospital Contacts and Designees

Complete this form and return to: **nbsinfo@health.ny.gov**

Newborn Screening Program
Wadsworth Center
New York State Dept of Health
PO Box 509
Albany, NY 12201-0509

Telephone (518) 473-7552

2013

Hospital_____ **Telephone** _____

Address_____ **PFI No.** _____

_____

CONTACTS

Chief Executive Officer: _____ **Telephone**_____
Email Address: _____ **Fax**_____
Director, Pediatrics: _____ **Telephone**_____
Email Address: _____ **Fax**_____
Director, Neonatology: _____ **Telephone**_____
Email Address: _____ **Fax**_____
Director, Nursing: _____ **Telephone**_____
Email Address: _____ **Fax**_____
Nurse Mgr, Nursery: _____ **Telephone**_____
Email Address: _____ **Fax**_____
Nurse Mgr, NICU: _____ **Telephone** _____
Email Address: _____ **Fax**_____
Medical Records: _____ **Telephone** _____
Email Address: _____ **Fax**_____
Newborn Coordinator: _____ **Telephone** _____
Email Address: _____ **Fax**_____

Person to receive & distribute blood collection forms & educational materials:

Name_____ **Title**_____ **Telephone** _____
Email Address: _____ **Fax**_____

Person to coordinate obtaining repeat specimens for abnormal and invalid results:

Name_____**Title**_____ **Telephone**_____
Email Address: _____ **Fax**_____

HIV Administrative Designee:

Name_____**Title**_____ **Telephone**_____
Email Address: _____ **Fax**_____

DESIGNEES

ABNORMAL TEST RESULTS (must be staff physician)

IMD/MCADD (PKU, etc) **Name** _____,MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

Hypothyroid/ CAH **Name** _____,MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

Hemoglobin **Name** _____,MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

HIV **Name** _____,MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

CF **Name** _____,MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

SCID **Name** _____, MD **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

SCREEN NEGATIVE AND INVALID RESULTS (Does not need to be staff physician)

Screen Negative **Name** _____ **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

Invalid **Name** _____ **Title:** _____ **Telephone** _____
Email _____ **Fax** _____

NOTE: In the absence of complete physician information on the MCH-3/DOH-1514 blood collection form, the above designees will also receive the physician copy of abnormal results. In the absence of a designee, the hospital CEO will receive notification of all invalid specimens and test results within acceptable limits.

Signature _____ **Date** _____
Chief Executive Officer