



Request for Original Newborn Screening Card

Date Today _____
Month DD, YYYY

Name of State Newborn Screening Laboratory _____

Street Address _____

City _____ State _____ ZIP Code _____

Fax Number (_____) _____

Dear Dr. _____ :
Director of state newborn screening laboratory

I/we hereby authorize you to send the original newborn screening card of our daughter/son, _____, _____ (Birth Date _____)
Last Name First Name Month DD, YYYY

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

Please include a copy of this letter with the sample.

Our daughter/son was born on _____, at _____
Month DD, YYYY Hospital/Other

in _____, _____.
City State

Sincerely,

_____ or _____
Mother's Signature Father's Signature

Attention Mayo Clinic Biochemical Genetics Laboratory:

Please contact Dr. _____ for clinical information
List physician or medical examiner's full name

about our daughter/son. This physician/medical examiner can be contacted at:

Phone (_____) _____ Fax (_____) _____

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