

# LITERATURE AND FORMS REQUISITION

Ohio Department of Health  
 Bureau of Public Health Labs  
 Newborn Screening Program  
 8995 East Main Street, Bldg 22  
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 FAX (614) 644-4648

SYMBOL <small>(Column for ODH Use Only)</small>	QUANTITY	ITEM #	TITLE	REMARKS
		O1PT	Why must my newborn be screened?	

Contact Person	Day-time Telephone Number (    )       -
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Send to: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Attn: \_\_\_\_\_

Date: \_\_\_\_\_

<b>For Ohio Department of Health Use Only Do Not Write in this Space</b>
Date Received:
Filled By:
Date Filled:
Order No.