Institutional Membership Form

Institutional Profile

Name of Health Facility (Please do not abbreviate)

Complete Address

Bldg. No, Street, Barangay | Town/District: | Province/City | Region No

Contact Numbers

Trunk Line (with area code) | Dept. of Pediatrics | Dept. of Obstetrics and Gynecology

Nursery/Pediatric Ward | Fax Number | Email Address

Hospital Classification

Category

- ☐ Birthing Homes (e.g. lying-in)
- ☐ Primary Care Hospital
- ☐ Secondary Care Hospital
- ☐ Tertiary Care Hospital
- ☐ Infirmary
- ☐ Others

Type

- ☐ Private
- ☐ Government
  - ☐ DOH Retained
  - ☐ LGU
  - ☐ Special Govt. Hosp

Bed Capacity:

Philhealth Accredited: ☐ No ☐ Yes If yes, Code:

Statistics

Average number per month

DELIVERIES | PAY | CHARITY/SERVICE | NORMAL VAGINAL | CESARIAN

Average number of days of DISCHARGE after deliveries

Courier Information

Available Courier in the Area

- ☐ Air21 / Fedex
- ☐ LBC
- ☐ JRS
- ☐ DHL
- ☐ LibCap
- ☐ Aboitiz

Others: Please specify

Courier Preference:

Postal Service Information

- ☐ Domestic Express Mail
- ☐ Priority Mail
- ☐ Ordinary Mail
- ☐ Registered Mail

If there are no courier and postal services available in your area, please specify other means of communication or transportation of NBS Samples

Preferred Mode of Payment for the Purchase of NBS Specimen Collection Kit

- ☐ Bank to Bank
  - ☐ Cheque
  - ☐ Cash
- ☐ Postal Money Order
- ☐ Courier
  - ☐ Cheque
  - ☐ Cash

Preferred Mode of Releasing of NBS Results

- ☐ Fax
- ☐ Email
- ☐ Courier

Newborn Screening Coordinators

(The institution is requested to designate a NBS coordinator and Assistant NBS Coordinator who will oversee the whole implementation of newborn screening in the institution and shall act as the contact person of the Newborn Screening Center. All communication and supplies shall be addressed to the NBS Coordinator. Any changes on the NBS coordinator should be communicated properly to the NSC).

NBS Coordinator Name

Mailing Address

Contact Numbers

Office | Home

Clinic | Fax

Mobile | Email

NBS Assistant Coordinator Name

Mailing Address

Contact Numbers

Office | Home

Clinic | Fax

Mobile | Email

NBS Orientation Attended: ☐ No ☐ Yes If yes, Date: ___/___/___ Place: Organizer:

We hereby declare that all information stated herein is true and correct. Filling and submitting this form signify our readiness to offer newborn screening.

Sincerely,

Name and Signature | Position | Office

For NSRC Use Only (Do not fill)

Hospital Code | NSC Assignment

Date Processed: | Processed by: