Newborn Screening Heel Stick Form Instructions

TIMING OF THE SPECIMEN COLLECTION

Specimens should be collected after 24 hours of birth. If a newborn is to be transfused before 24 hours of age, collect the specimen prior to transfusion.

COMPLETING THE NEWBORN SCREENING CARD

It is extremely important to fill out the newborn screening card completely and accurately. The specimen submitter is responsible for the accuracy and completeness of the information on the newborn screening card. The card will be scanned into the database so legibility is critical. **Press firmly using a black ball point pen**, and record the following information in the spaces provided.

INFANT INFORMATION

BABY'S NAME: Record last name followed by first name. If no name is given by the time of specimen collection, the mother's last name followed by "boy" or "girl" should be used. **DO NOT LEAVE BLANK.**

GESTATIONAL AGE: Record weeks of gestation at time of birth. **Note:** Do not use fractions.

BABY'S ADDRESS: Record the current street address, followed by apartment or lot number, city, state and zip code. This information is needed to locate newborns in need of clinical evaluation or retesting.

DATE OF BIRTH: Use a six-digit number (mm/dd/yy) for date of birth. For example, a birth on June 5, 2009 would be recorded as 06/05/09.

BIRTH TIME: Record birth in military time. For example, a birth at 4:30 pm would be recorded as 1630. **Note:** This information is important in determining the age of the newborn at the time of collection.

DATE OF COLLECTION: Use a six-digit number-(mm/dd/yy) representing the date on which the specimen was collected.

TIME OF COLLECTION: Record time of specimen collection in military time. For example a collection at 9:30 am would be recorded as 0930.

PATIENT/HOSPITAL ID #: Record the birth hospital's identification or medical record number for the infant.

BIRTH ORDER: Only fill out this area in instances of multiple births. Completely shade in a circle to record birth order by "A", "B", "C" to indicate birth order of child.

SEX: Completely shade in the appropriate circle to designate newborn's gender as male or female.

TPN (TOTAL PARENTERAL NUTRITION): Completely shade in the appropriate circle.

TYPE OF FORMULA: Name of formula newborn is on at time of collection.

WEIGHT AT COLLECTION: Record the current weight in grams in the boxes provided. ***Do not use pounds and ounces.***

HOSPITAL OF BIRTH: Record the name of the birth hospital.

INFANT BLOOD TRANSFUSION: Completely shade in a circle "yes" or "no" to indicate whether or not the newborn was transfused **prior** to specimen collection. If yes, give the date the transfusion occurred (mm/dd/yy).

MOTHER INFORMATION:

MOTHER'S NAME: Record last name followed by first name.

MOTHER'S SOCIAL SECURITY NUMBER: Record mother's nine digit social security number. This information is used to help locate newborns.

MOTHER'S TELEPHONE NUMBER OR CONTACT NUMBER: Record mother's or her contact's ten digit telephone number (area code plus telephone number).

MOTHER'S DATE OF BIRTH: Record the mother's date of birth (mm/dd/yy).

PRIMARY CARE PHYSICIAN INFORMATION:

PRIMARY CARE PHYSICIAN'S NAME: Record the last name, followed by the first name, of the physician or health care provider to be notified of a positive or unsatisfactory newborn screening test.

PRIMARY CARE PHYSICIAN'S TELEPHONE NUMBER: Record Physician's ten digit telephone number (area code plus telephone number).

SENDER INFORMATION:

Sender's Name: Record the name of the sender. This is the name of the medical provider who collects the newborn screen. The screening results will be mailed to the sender.

Sender's Telephone: Record senders ten digit telephone number (area code plus telephone number).

Sender's Address: Record the sender's street address followed by the city, state and zip code.

NEWBORN SCREENING

La. DHH Office of Public Health
DIVISION OF
LABORATORY SERVICES

FOLD BACK DURING DRYING BUT **DO NOT REMOVE** THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.

PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY.

AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.

BIOHAZARD

LABORATORY REQUEST AND REPORT FORM WRITE FIRMLY - Use Ballpoint Pen - Print Legibly MAIL FORM(S) DAILY

Place Lab OPH Label Here

Baby's Last Name | Baby's First Name | Gestational Age Weeks

Baby's Address | Date of Birth M M D D Y Y | Time of Birth Military Time

City | State | Zip Code | Date of Collection M M D D Y Y | Time of Collection Military Time

Patient/Hospital ID # | Birth Order A B C | Sex M F | TPN Yes No | Type of Formula | Weight at Collection

Hospital of Birth | Infant Blood Transfusion Yes No | If yes Date of Transfusion M M D D Y Y

Mother's Last Name | Mother's First Name | MI

Mother's Social Security # | Mother's Telephone # or Contact # | Mother's Date of Birth M M D D Y Y

*Primary Care Physician - | Primary Care Physician Phone #

*Sender, please provide a copy of analytical results to the above named primary care physician.

Sender's Name | Sender's Telephone #

Sender's Address

City | State | Zip Code | 2009 B

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