

DRIED BLOOD SPOT CARD

ALL INFORMATION MUST BE PRINTED
 2019-07-31

NEWBORN SCREENING

TO AVOID RECOLLECTION - Accurately complete the entire form

First Specimen All tests
 Home Birth
 Repeat Specimen
 Reason: <24 hr.
 Unsatisfactory
 Abnormal
 Transfused
 Inconclusive

Infant's Last Name: First _____ Previous Last Name _____
 Birth Date: ____/____/____ Time of Birth: ____:____ Use Military Time Only
 Date Collected: ____/____/____ Time Collected: ____:____ Use Military Time Only
 Hospital of Birth Use Code: _____ Hospital or H.D. Use Code: _____ Medical Record Number: _____
 Transfused: Yes No When? _____

Physician's Name: _____ Physician's Phone: _____
 Additional Information: _____
 Submitter's Name and Address: _____

SEX: 1. Male 2. Female
 RACE: 1. White 2. Black 3. Asian 4. Am. Ind. 5. Other
 ETHNICITY: 1. Hispanic 2. Non-Hispanic
 Transfused: Yes No
 If Yes, Date and Time: ____/____/____
 of Last Transfusion: ____:____
 Gestation: ____ Weeks Infant's Age: ____ Grams
 Birth Weight: ____ Grams
 Feeding: 1. Breast 2. Soy 3. IV 4. Lactose 5. TPN
 Monogram (Yes/No): Yes No

MOTHER'S INFORMATION

Mother's Current Last Name: First _____ Maiden _____
 Address: _____ Mother's DOB: ____/____/____
 City: _____ State: _____ Zip: _____
 Phone: _____ Medicaid Number: _____
 Mother's Social Security No. _____ Use 2 Digit County Code: _____

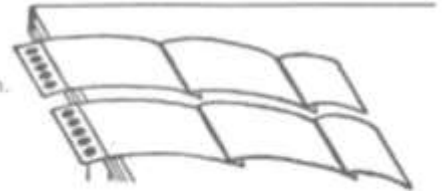
Critical Congenital Heart Disease Screening

Initial Q2 Screen: ____/____/____ Date: ____:____ Military time
 WBN NICU
 Final Result: Passed Failed
 Echocardiogram performed? Yes No

PerkinsElmer Genetics, Inc. 90 Emerson Lane Bridgeville, PA 15017 (412) 220-2300
 SPECIMEN CONTROL NUMBER: XXXXXXXX
 Results are based on the assumption that the infant has not been transfused.

INSTRUCTIONS

1. Hold infant's limb in a dependent position to increase blood flow.
2. Clean heel thoroughly. Wipe with alcohol and dry before puncturing.
3. Puncture heel with sterile lancet deep enough to assure free flow of blood.
4. Wipe away first drop and discard.
5. Allow a large drop of blood to form on infant's heel. Apply the back side of the filter paper directly to the puncture site where the drop of blood has formed. **The drop of blood should be large enough to approximately fill one circle.**
DO NOT: a) Apply more than one drop of blood per circle.
DO NOT: b) Apply blood to both front and back of filter paper.
6. Apply blood to all circles.
7. Allow blood spots to completely dry in a horizontal position at room temperature for a minimum of 4 hours (see diagram). Do not stack specimens while specimen is exposed. After drying, rewrap this cover sheet to its original position to protect specimen.
8. Send by Pre-Paid Overnight Courier within 24 hours of collection to:
9. If you have questions please call:



HOW TO ORDER DRIED BLOOD SPOT CARDS

To order Newborn Screening Pamphlets and dried blood spot cards complete a Newborn Screening Supply Form and fax to 601-576-7498 or call 601-576-7619.

INSTRUCTIONS FOR DRIED BLOOD SPOT CARD (DBS) COMPLETION

Results may be delayed for screening specimens submitted with incomplete information.

ALWAYS check the specimen card expiration date located on the far left side of the filter paper, next to the hour glass, noted by the year and date. Expired cards are not acceptable. All information must be legible.

TOP LINE

First Specimen– If it is the first newborn screening specimen (dried blood spot) collected on the infant, place an “X” in the blank provided.

Home Birth – If the newborn was born at home, place an “X” in the blank provided.

Repeat Specimen – If the test is a repeat newborn screening specimen collected on the infant, place an “X” in the blank provided.

Repeat Specimen Reason – Put an “X” by the appropriate reason for a repeat Specimen; < 24 hr, Unsatisfactory, Abnormal, Transfused, Inconclusive.

REQUIRED INFANT INFORMATION

Infant’s Last/First Name – Write infant’s name in order as shown: Last name, first name, previous last name. Ensure the name is spelled correctly. If the infant’s first name is not available, put last name, followed by Boy/Girl. (Example: Smith, Baby Boy).

Previous Last Name – If the infant’s last name is different from the name given at birth, indicate the previous/original name in the blank provided. (Smith, John; Brown, Boy).

Birth Date – Write the date of birth using numbers only in the blank provided. (Example: December 25, 2002 will appear as 12-25-02).

Time of Birth – Write the time of birth using **MILITARY TIME ONLY** in the blank provided. (Example: 2:30 p.m. will appear as 1430).

Date Collected – Write the date the specimen was collected using numbers only in the blank provided. (Example: December 2, 2003 will appear as 12-02-03).

Time Collected – Write the time the specimen was collected using **MILITARY TIME ONLY** in the blank provided. (Example: 8:00 p.m. will appear as 2000).

Birth – Write an “X” in the blank provided. (EXAMPLE: in the case of twins/triplets, write an “X” to indicate the birth order of the infant to indicate A or B). For triplets or more use #3 blank and indicate C, D, or E etc.

Hospital of Birth Code or Health Department Code – Write the hospital code/health department code in the appropriate blank provided. **NOTE:** If the infant is born in the same hospital in which the specimen is collected, then both the hospital of birth code and hospital collected code will be the same. If the infant is born in one hospital, but transferred to another hospital prior to the specimen being collected, the hospital collection code will be different from that of the hospital of birth. **When the specimen is collected or repeated by the health department, the health department county code is entered into the health department collected blank.**

Medical Record Number – Write the infant’s medical record number in the blank provided.

Transferred – If the infant has been transferred to another facility; check “yes” and write the name of the facility in the space provided.

Physician’s Name – Write the name and contact information of the healthcare professional who will be providing local medical care for the infant in the blank provided. In the event of a homebirth, **provide the name of the midwife or person attending the homebirth, with contact information.**

Additional Information – Use these lines to provide the following information:

- Collection of a PRE TRANSFUSION specimen
- Infant is ADOPTED (give the name and address of the adoption agency, attorney or physician handling the adoption)
- Infant discharged/ expired from the hospital prior to newborn screening collection.
- **INCARCERATION** – if mother will return to an incarceration facility, write INMATE and to whom the infant has been discharged and the contact information.

Submitter Name/Address – Write the name and address of the hospital/health department (submitter) in the blank provided.

Specimen Collected By – Write initials of person collecting specimen in the blank provided.

Sex – Write an “X” in the appropriate blank provided.

Race – Write an “X” in the appropriate blank provided.

Ethnicity – Write an “X” in the appropriate blank provided.

Transfused – **Collect specimen PRIOR to transfusion** if at all possible. Provide

the **date and time of the last transfusion for each specimen collected** in the space provided (Example: December 15, 2002 at 10:00 a.m. will appear as 12-15-02/1000.)

NOTE:

- **Ideal collection time: 24-48 hours of age**
- **Transfusion required > 24 hours of age: collect specimen prior to Transfusion**
- **Transfusion required < 24 hours of age: collect specimen prior to transfusion and 2-4 days after the transfusion**
- **Transfusion required but no specimen collected prior to transfusion: collect specimen 2-4 days, 2-4 weeks and > 90 days after transfusion**

Note: Anticoagulants should not be used in the collection of newborn screening specimens. In cases where it is unavoidable, only heparin should be used and its presence in the sample should be noted on the filter paper.

Gestation/Infant's Age – Write the gestational age of the infant at birth and the age of the infant at the time of collection in the blank provided.

Birth Weight – Write the infant's weight in grams, **AT THE TIME OF BIRTH** in the blank provided. If specimen is collected > 14 days of age, write current weight in grams.

Feeding – Write an “X” in the appropriate blank provided, indicating the infant's feeding status at the time of collection. More than one blank may be marked if appropriate.

Meconium Ileus – Check the blank if appropriate, to indicate the presence of a meconium ileus.

MOTHER'S INFORMATION

Mother's Current Last/First Name – Write mother's full name, as specified at time of delivery in the blank provided (Example: Smith, Caroline). Enter the mother's maiden name in the space provided. **(NOTE: If the infant is ADOPTED, do not give the birth mother's information. In the case of ADOPTION, this area should reflect the name of the agency, physician or attorney handling the adoption.)**

Mother's Date of Birth – Write Mother's date of birth using numbers only in the blank provided. (Example: December 25, 1983 will appear as 12-25-02).

Address/Phone Number – Write the physical street address, **(DO NOT GIVE P.O. BOX)**, and/or apartment number, as well as the city, state, and zip code in the blanks provided. Write the telephone number or emergency contact number where a voicemail/message can be accepted, in the blanks provided. **(NOTE: In the case of ADOPTION, give the agency, physician or attorney name, address and phone number handling the adoption in the**

blanks provided.)

Medicaid Number/Mother's Social Security Number – Write Mother's Medicaid Number, if it applies and Social Security Number in the blanks provided.

County of Residence – Write the county two digit code where the infant resides in the space provided (Example Hinds County/25).

NOTE: In the event an infant is a “Drop Off Baby”, assign the baby a name. The date the baby was dropped at the hospital should be used as the date of birth, and the approximate time the baby was left should be used as the time of birth, unless other information is known to the hospital. The hospital code should be entered in the space provided for the hospital of birth and hospital collected. In the box provided for Physician's Name, note the emergency medical services provider. This will allow for adequate follow-up/tracking in the event of an abnormal or positive newborn screen.

CRITICAL CONGENITAL HEART DISEASE (CCHD)

In the spaces provided, write the date/time the initial pulse ox screening was performed. If pulse ox was not performed, indicate the reason why. In the appropriate space, indicate the pulse oximetry screening outcome “passed” or a “failed” screen. Indicate the location of the newborn at the time of screening by checking WBN if newborn is in the Well Baby Nursery of NICU if newborn is in the Newborn Intensive Unit. Indicate if an echocardiogram was performed. DO NOT delay sending the dried blood spot specimen to the screening lab to provide CCHD screening data. Complete the “Delayed Screening Form” and mail or FAX the delayed CCHD screening data to the newborn screening program.

HEARING SCREENING

This section of the newborn screening form should be completed by the hospital of birth prior to discharge. Check the appropriate test performed, i.e. ABR/OAE, and the appropriate result for each ear, i.e., pass/refer. If the hearing screening is not performed, leave this section blank. DO NOT delay sending the dried blood spot specimen to the screening lab to provide hearing screening data.

OFFICE MECHANICS/FILING/RETENTION:

The yellow NCR copy of the dried blood spot card should be kept by the submitting hospital of birth /county health department to ensure the results are received by the submitting hospital or county health department. Once the newborn screen result is received, the yellow copy can be destroyed. The electronic copy/hard copy of the newborn screening result should be filed in the infant's electronic medical record/paper medical record and retained according to hospital/county health department policy.

