Newborn Screening

Specimen Collection Forms

A Guide to New Jersey's
Revised Newborn Screening Forms

October 2013

What's New?

5 PART COLOR FORM

- Initial Specimen Forms are GREEN
- Repeat Specimen Forms are GOLDENROD

NJ Health
New Jersey Department of Health

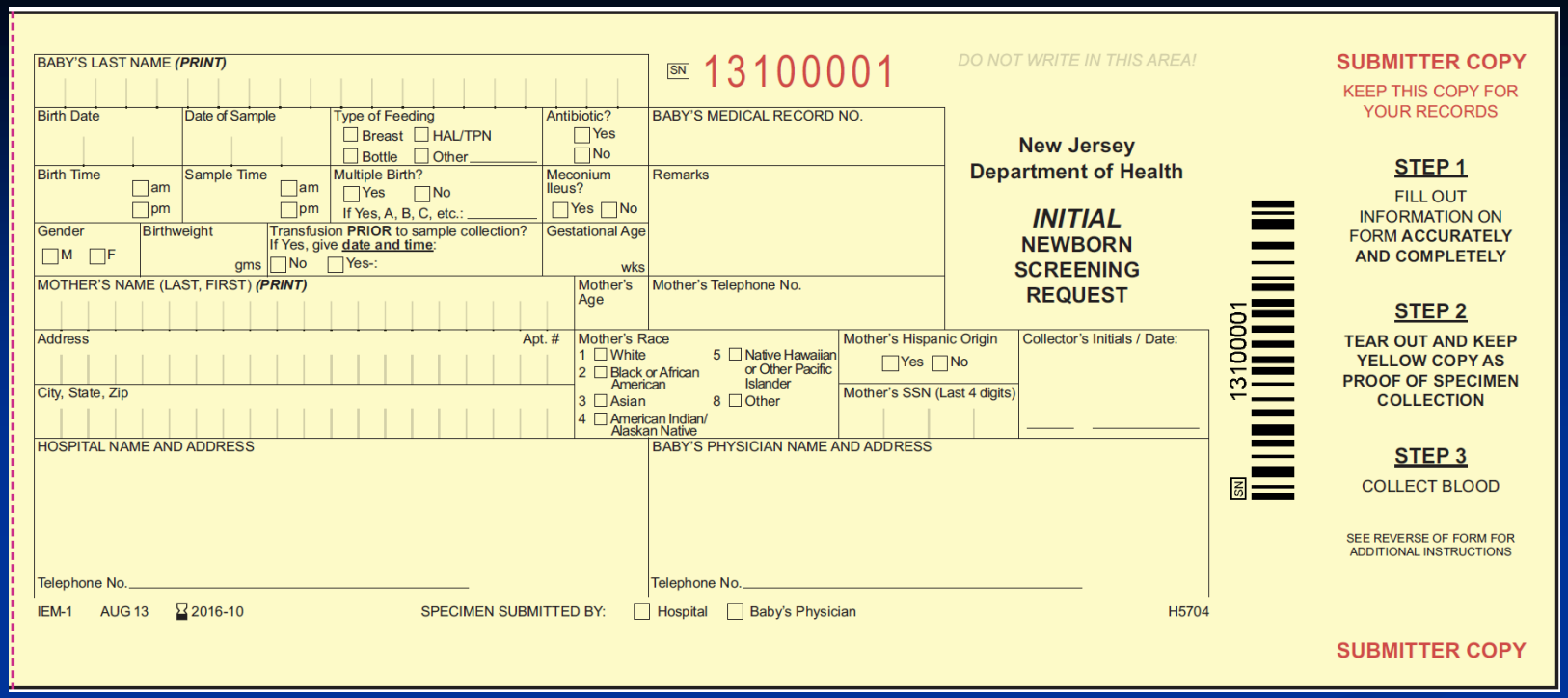
State of New Jersey
NEWBORN SCREENING

Parent Copy

- Actively involves the parents
- Can be used when contacting lab or Voice Response System for results
- Serial number avoids problem of misspellings or different last names

NJ Health
New Jersey Department of Health

State of New Jersey
NEWBORN
SCREENING



BABY'S LAST NAME *(PRINT)*

SN 13100001

DO NOT WRITE IN THIS AREA!

Birth Date	Date of Sample	Type of Feeding	Antibiotic?	BABY'S MEDICAL RECORD NO.
		☐ Breast ☐ HAL/TPN ☐ Bottle ☐ Other_____	☐ Yes ☐ No	
Birth Time ☐ am ☐ pm	Sample Time ☐ am ☐ pm	Multiple Birth? ☐ Yes ☐ No If Yes, A, B, C, etc.: _____	Meconium Ileus? ☐ Yes ☐ No	Remarks
Gender ☐ M ☐ F	Birthweight gms	Transfusion **PRIOR** to sample collection? If Yes, give **date and time**: ☐ No ☐ Yes-:	Gestational Age wks	

MOTHER'S NAME (LAST, FIRST) *(PRINT)* | Mother's Age | Mother's Telephone No.

Address Apt. #

City, State, Zip

Mother's Race
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ American Indian/ Alaskan Native
5 ☐ Native Hawaiian or Other Pacific Islander
8 ☐ Other

Mother's Hispanic Origin ☐ Yes ☐ No

Mother's SSN (Last 4 digits)

Collector's Initials / Date:

HOSPITAL NAME AND ADDRESS

Telephone No._____

BABY'S PHYSICIAN NAME AND ADDRESS

Telephone No._____

IEM-1 AUG 13 2016-10 SPECIMEN SUBMITTED BY: ☐ Hospital ☐ Baby's Physician H5704

New Jersey Department of Health

***INITIAL* NEWBORN SCREENING REQUEST**

13100001 SN

SUBMITTER COPY

KEEP THIS COPY FOR YOUR RECORDS

STEP 1

FILL OUT INFORMATION ON FORM **ACCURATELY AND COMPLETELY**

STEP 2

TEAR OUT AND KEEP YELLOW COPY AS PROOF OF SPECIMEN COLLECTION

STEP 3

COLLECT BLOOD

SEE REVERSE OF FORM FOR ADDITIONAL INSTRUCTIONS

SUBMITTER COPY

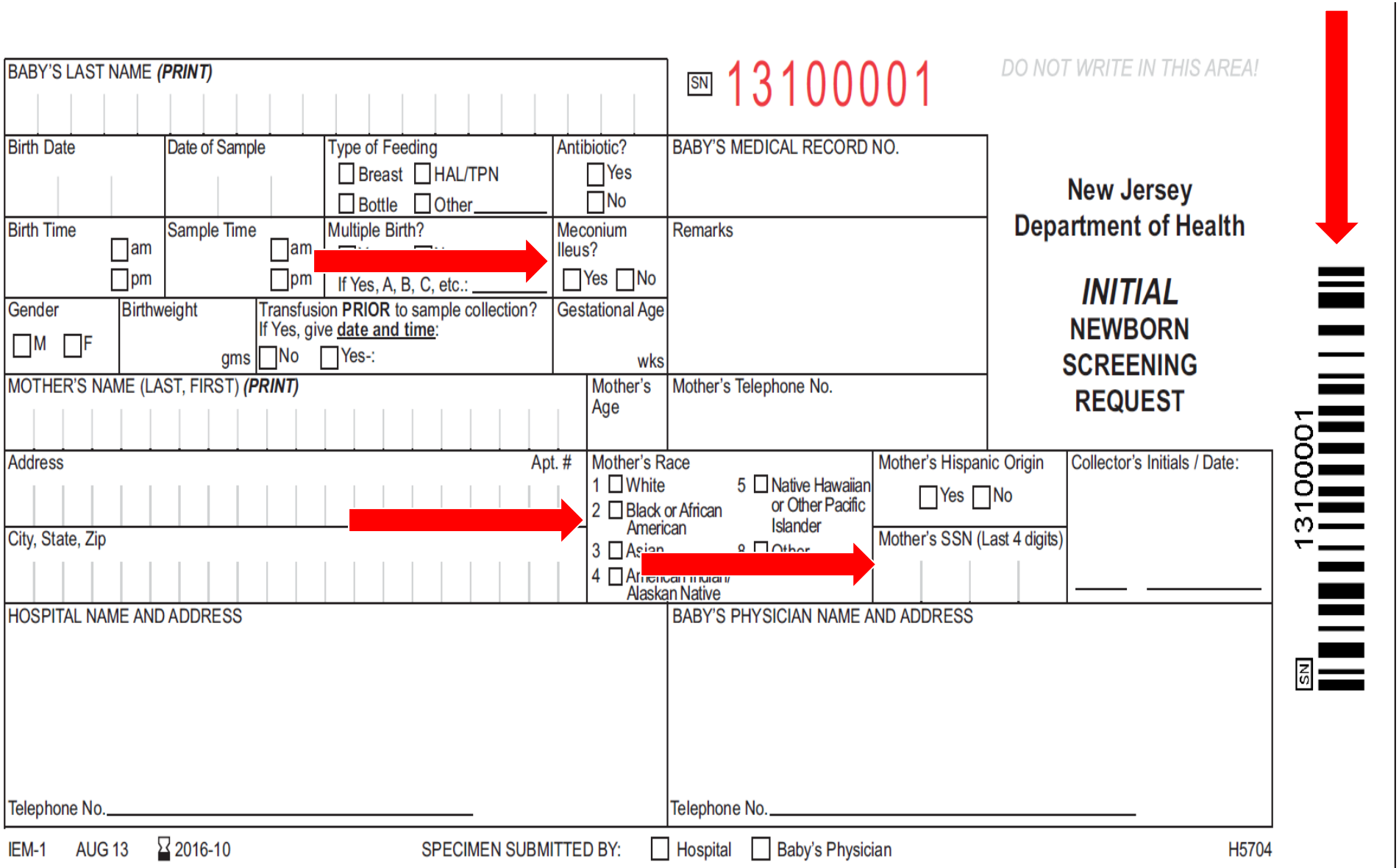
Submitter Copy

- Retain for record of testing
- Use to monitor QA/QC – document how the specimen was completed
- Can be used when contacting lab or Voice Response System for results
- Serial number avoids problem of misspellings or different last names
- Assist with tracking UPS packages
- Ensure receipt of results reports

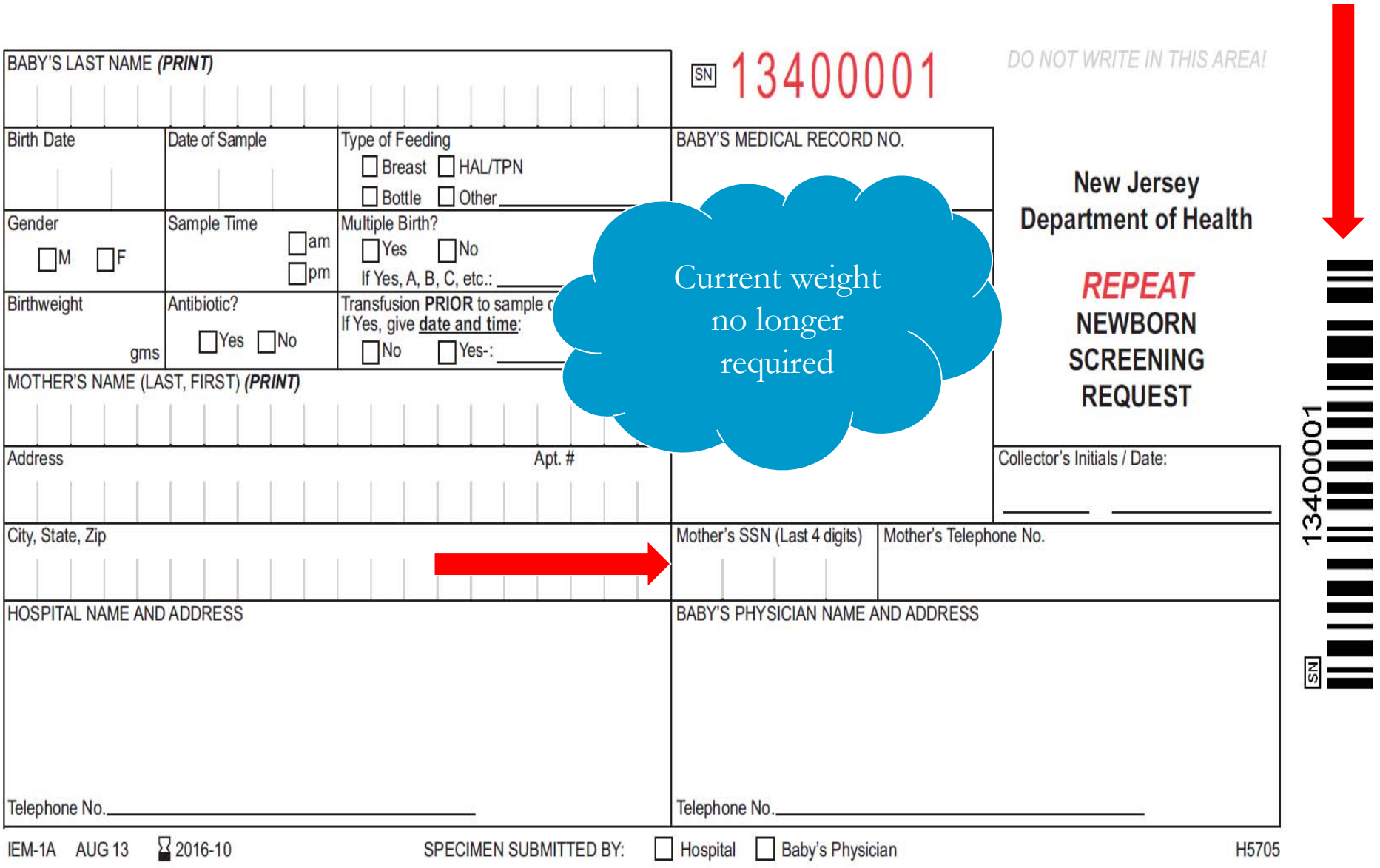
NJ Health New Jersey Department of Health

State of New Jersey NEWBORN SCREENING

Changes In The Form



Initial Specimens



Repeat Specimens

Completing The Form

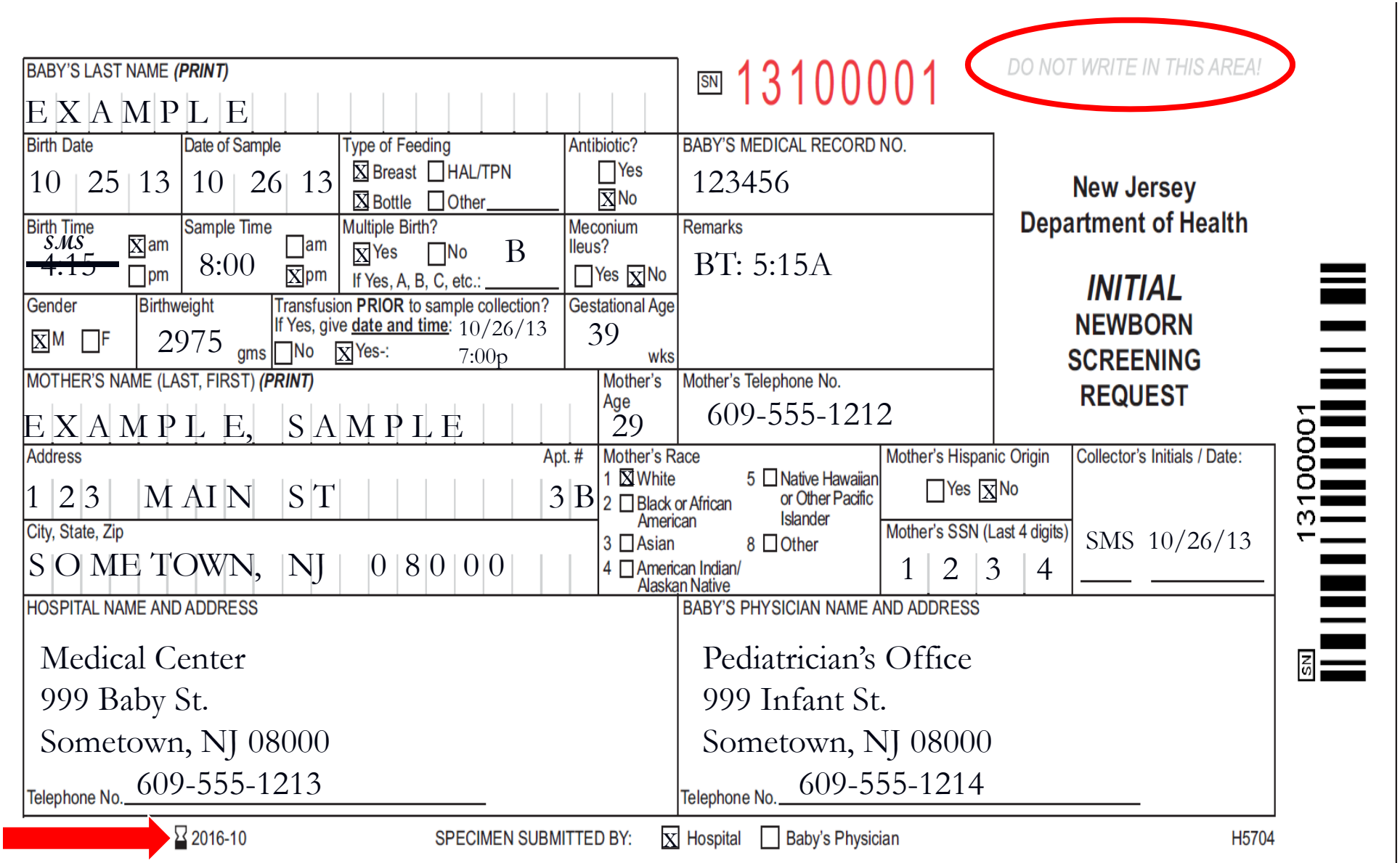
N.J.A.C. 8:18-1.4(a)7.i.

The specimen collection forms shall be filled in completely, accurately and legibly

- Print clearly in Pen.
- Press firmly to assure legibility.

Parent Copy

- Fill in baby's last name
- Tear off colored top copy and give to parents
- Complete remaining form after removing the Parent Copy



BABY'S LAST NAME *(PRINT)*: EXAMPLE

SN 13100001

DO NOT WRITE IN THIS AREA!

Birth Date	Date of Sample	Type of Feeding	Antibiotic?	BABY'S MEDICAL RECORD NO.
10 25 13	10 26 13	☒ Breast ☐ HAL/TPN ☒ Bottle ☐ Other	☐ Yes ☒ No	123456

Birth Time	Sample Time	Multiple Birth?	Meconium Ileus?	Remarks
~~SMS 4:15~~ ☒ am ☐ pm	8:00 ☐ am ☒ pm	☒ Yes ☐ No B If Yes, A, B, C, etc.:	☐ Yes ☒ No	BT: 5:15A

Gender	Birthweight	Transfusion PRIOR to sample collection? If Yes, give date and time:	Gestational Age
☒ M ☐ F	2975 gms	☐ No ☒ Yes-: 10/26/13 7:00p	39 wks

MOTHER'S NAME (LAST, FIRST) *(PRINT)*: EXAMPLE, SAMPLE

Mother's Age: 29

Mother's Telephone No.: 609-555-1212

Address: 123 MAIN ST Apt. # 3B

City, State, Zip: SOMETOWN, NJ 08000

Mother's Race
1 ☒ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ American Indian/ Alaskan Native
5 ☐ Native Hawaiian or Other Pacific Islander
8 ☐ Other

Mother's Hispanic Origin: ☐ Yes ☒ No

Mother's SSN (Last 4 digits): 1234

Collector's Initials / Date: SMS 10/26/13

HOSPITAL NAME AND ADDRESS

Medical Center
999 Baby St.
Sometown, NJ 08000
Telephone No. 609-555-1213

BABY'S PHYSICIAN NAME AND ADDRESS

Pediatrician's Office
999 Infant St.
Sometown, NJ 08000
Telephone No. 609-555-1214

2016-10

SPECIMEN SUBMITTED BY: ☒ Hospital ☐ Baby's Physician

H5704

New Jersey Department of Health

INITIAL NEWBORN SCREENING REQUEST

13100001 SN

NJDOH/NBS LAB COPY

Initial Specimens

NJ Health New Jersey Department of Health

State of New Jersey NEWBORN SCREENING

BABY'S LAST NAME *(PRINT)*

SN 13400001

DO NOT WRITE IN THIS AREA!

Birth Date	Date of Sample	Type of Feeding ☐ Breast ☐ HAL/TPN ☐ Bottle ☐ Other _____	BABY'S MEDICAL RECORD NO.
Gender ☐M ☐F	Sample Time ☐am ☐pm	Multiple Birth? ☐Yes ☐No If Yes, A, B, C, etc.: _____	NICU/SCN? ☐Yes ☐No
Birthweight gms	Antibiotic? ☐Yes ☐No	Transfusion **PRIOR** to sample collection? If Yes, give **date and time**: ☐No ☐Yes-: _____	Remarks

MOTHER'S NAME (LAST, FIRST) *(PRINT)*

Address Apt. #

City, State, Zip

Mother's SSN (Last 4 digits)

Mother's Telephone No.

HOSPITAL NAME AND ADDRESS

Telephone No._____

BABY'S PHYSICIAN NAME AND ADDRESS

Telephone No._____

Collector's Initials / Date: _____ _____

New Jersey Department of Health

REPEAT

NEWBORN SCREENING REQUEST

13400001 SN

IEM-1A AUG 13 2016-10

SPECIMEN SUBMITTED BY: ☐ Hospital ☐ Baby's Physician

H5705

NJDOH/NBS LAB COPY

Repeat Specimens

NJ Health New Jersey Department of Health

State of New Jersey NEWBORN SCREENING

In Summary

- Colored "Receipt" for parents
- Submitter copy
- New/Revised fields for diagnostic information and patient privacy
- Accurate information ensures accurate results

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