

	
Form Name	New Jersey IEM-1a
Design ID	
Version	
Design Date	08/09/24 JM
Approved <input type="checkbox"/>	Not Approved <input type="checkbox"/>
Signature	
Print Name	Date







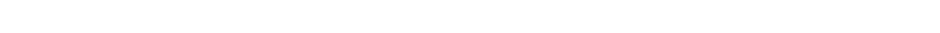



















Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

Perf: 3/4"

BABY'S LAST NAME (PRINT) [REDACTED] SN 24400001

DO NOT USE THIS FORM AFTER 08/31/2029

Instructions to Submitter:
After entering the newborn's name, remove this copy and give it to the parents of this newborn.

Parents and Legal Guardians,
Newborn Screening is an important public health service that can protect your baby. Babies may look healthy but have certain rare health problems, which can be found by taking a small amount of blood from a baby for testing. The Newborn Screening program currently conducts tests for more than 60 disorders.

Five blood drops have been taken from your baby's heel and sent to the New Jersey Newborn Screening Laboratory for initial testing, which will be completed in the next few days. You have received the brochure "These Tests Could Save Your Baby's Life," which is also available at <https://www.nj.gov/health/fhs/nbs/bloodspot/>. This brochure has more information about Newborn Screening.

Please take this notice to your baby's doctor, who can get a copy of your baby's test results by contacting the Newborn Screening Laboratory.

Por favor lleve esta carta al doctor de su bebé.

State of New Jersey NEWBORN SCREENING
New Jersey Department of Health
<http://www.newbornscreening.nj.gov>

PARENT COPY

DO NOT REMOVE THIS COVER FLAP
It is for the protection of the specimen and the specimen handlers.

OPEN this flap to uncover the circles for blood collection **AND** leave open while drying.

BEFORE submitting the specimen:
Make sure the spots are completely dry and the protective flap is folded over the dried blood spots.

 BIOHAZARD

Folded Flap: 1 1/2"

Total Form Height (all parts)
4" (106mm)

Total Form Length (flap folded)
10" (254mm)

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
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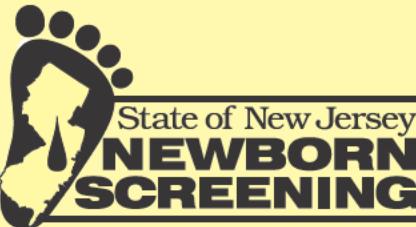
PARENT COPY

Face of Part 1 (copy on face)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers
Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

Total Form Height
(all parts)
4" (106mm)



New Jersey
Department of Health

<http://www.newbornscreening.nj.gov>

Part 1: 20# Canary Bond
Black and Red 185 ink face,
Black ink only on back,
(1) 3/16" Red 185 mechanical numbers on face,
(1) static QR code on back,
Shaded Words & Lines = 20% Black,
8 1/2" (215.9mm)

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

Back of Part 1 (copy on face)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers
Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

In accordance with Department of Health (DOH) policy, the sample taken from your baby will be securely stored for 2 years to ensure the integrity of your baby's tests results (for example, to rule out false positive or false negative results). If we do not hear otherwise from you, we will destroy the sample after 2 years.

At your request, the blood sample from your baby's Newborn Screening can be:

1. Destroyed at any time after initial testing, including before your child is 2 years old.
2. Stored for additional time, up to 8 years beyond the initial 2-year retention period.

DOH uses blood samples from the Newborn Screening program only for the following purposes: (1) newborn screening for your baby; (2) routine quality assurance and quality control for DOH's lab; and (3) developing new tests for disorders. Any blood samples used for the second or third purposes will be de-identified—that is, unlinked from your baby's identifying information.

The sample taken from your baby will not be released in identified form (that is, with identifying information about your baby) to non-law enforcement third parties without your consent. DOH will release your baby's identified blood samples to law enforcement (for example, if your child went missing) only with your consent or consistent with the Attorney General's binding Law Enforcement Directive (available at www.nj.gov/oag/dcji/agguide/directives/). De-identified samples will be released to third parties only as allowed by federal law.

 Scan the QR code below to access the full Newborn Screening bloodspot retention policy, or to fill out and submit either a destruction form or an extended-retention form. These forms are also available at:

www.nj.gov/health/phel/documents/destruction-form.pdf and
www.nj.gov/health/phel/documents/extended-retention-form.pdf

Perf: 3/4"

Total Form Height
(all parts)
4" (106mm)

Part 1: 20# Canary Bond
Black and Red 185 ink face,
Black ink only on back,
(1) 3/16" Red 185 mechanical numbers on face,
(1) static QR code on back,
Shaded Words & Lines = 20% Black,
8 1/2" (215.9mm)

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

Perf: 3/4"

BABY'S LAST NAME (PRINT)			SN 24400001 DO NOT WRITE IN THIS AREA!		
Birth Date	Date of Sample	Type of Feeding	BABY'S MEDICAL RECORD NO.		
		<input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other			
Gender	Sample Time	Multiple Birth?	NICU/SCN? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, A, B, C, etc.: _____	Remarks		
Birthweight	Antibiotic?	RBC Transfused PRIOR to sample collection? If Yes, give date and time: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	REPEAT NEWBORN SCREENING REQUEST		
gms	<input type="checkbox"/> Yes <input type="checkbox"/> No				
MOTHER'S NAME (LAST, FIRST) (PRINT)			Mother's Telephone No. Collector's Initials / Date:		
Address Apt. #					
City, State, Zip					
HOSPITAL NAME AND ADDRESS			BABY'S PHYSICIAN NAME AND ADDRESS		
Telephone No. _____			Telephone No. _____		
IEM-1A AUG 24 2029-08-31		SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician		H5783	
NJDOH/NBS LAB COPY					

Face of Part 2 (no copy on back)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers
Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

Total Form Height
(all parts)
4" (106mm)

Part 2: 20# White CB
Black and Red 185 ink face only,
(1) 3/16" Red 185 mechanical numbers,
(1) Code 128 barcode with (1) human readable,
Shaded Words & Lines = 20% Black,
8 1/2" (215.9mm)

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

Perf: 3/4"

BABY'S LAST NAME (PRINT)			DO NOT WRITE IN THIS AREA		
			SN 24400001		
Birth Date	Date of Sample	Type of Feeding <input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other _____	BABY'S MEDICAL RECORD NO.		
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Sample Time <input type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, A, B, C, etc.: _____	NICU/SCN?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Birthweight gms	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RBC Transfused PRIOR to sample collection? If Yes, give date and time: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____	Remarks		
MOTHER'S NAME (LAST, FIRST) (PRINT)					
Address			Apt. #		
City, State, Zip			Mother's Telephone No.	Collector's Initials / Date:	
HOSPITAL NAME AND ADDRESS			BABY'S PHYSICIAN NAME AND ADDRESS		
Telephone No. _____			Telephone No. _____		
SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician					
ITEM-1A AUG 24 2029-08-31					
H5783					
SEE REVERSE OF FORM FOR ADDITIONAL INSTRUCTIONS					

Face of Part 3 (no copy on back)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers

Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

Part 3: 22# Canary CFB
Black and Red 185 ink face only,
(1) 3/16" Red 185 mechanical numbers,
(1) Code 128 barcode with (1) human readable,
Shaded Words & Lines = 20% Black,
9 7/8" (250.8mm)

Total Form Height
(all parts)
4" (106mm)

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

SEE REVERSE OF FORM FOR
ADDITIONAL INSTRUCTIONS

SUBMITTER COPY

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

Perf: 3/4"

SN 24400001

DO NOT WRITE IN THIS AREA!

New Jersey
Department of Health

**REPEAT
NEWBORN
SCREENING
REQUEST**

24400001

SN 23400001

Completely fill 5 circles with blood.

BABY'S LAST NAME (PRINT)		
Birth Date	Date of Sample	Type of Feeding <input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Sample Time <input type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, A, B, C, etc.: _____
Birthweight gms	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No	RBC Transfused PRIOR to sample collection? If Yes, give date and time: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____
MOTHER'S NAME (LAST, FIRST) (PRINT)		
Address		Apt. #
City, State, Zip		
HOSPITAL NAME AND ADDRESS		
Telephone No. _____		
IEM-1A AUG 24 2029-08-31 SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician		
LOT 116983 / 30320006 Revity™ 226 Ahlstrom		
H5783		
NJDOH/NBS LAB COPY		

Total Form Height
(all parts)
4" (106mm)

Part 4: 33# White CF
Black and Red 185 ink face only,
(1) 3/16" Red 185 mechanical number on face,
(1) Code 128 barcode with (1) human readable on face,
Shaded Words & Lines = 20% Black,
8 1/2" (215.9mm)

Part 5: [REDACTED]
ID0606 ink face and
back, (1) 3/16" Black
Mechanical Numbers
Face only, Circles are
12.7mm ID,
2" (50.8mm)

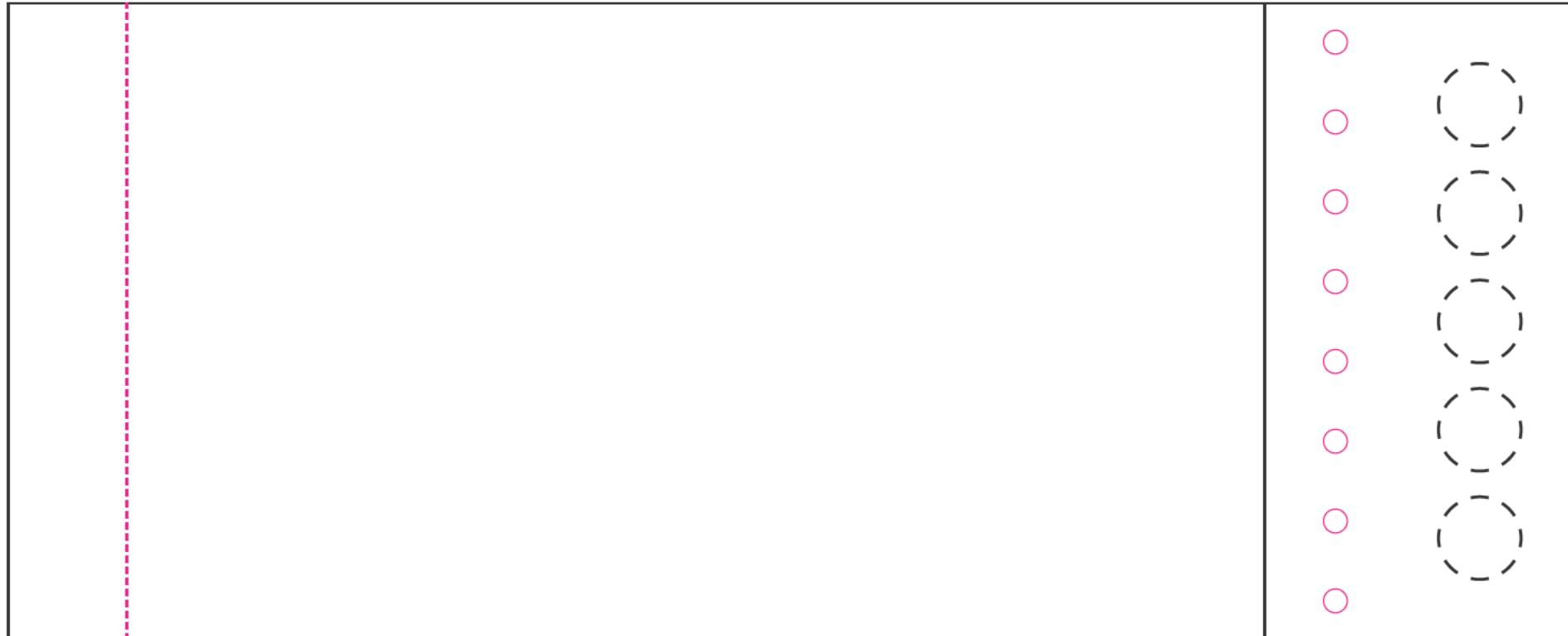
Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Back of Parts 4 and 5 (copy on face)
 All measurements can vary +/- 1/16" (1.6mm).
 Manufacturing equivalent substitutions allowed for demographic papers
 Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

Dotted Magenta lines signify perf lines.

○ ○ ○ Magenta circles signify line holes.

Perf: 3/4"



Part 4: 33# White CF
 Black and Red 185 ink face only,
 (1) 3/16" Red 185 mechanical number on face,
 (1) Code 128 barcode with (1) human readable on face,
 Shaded Words & Lines = 20% Black,
 8 1/2" (215.9mm)

Part 5: [REDACTED]
 ID0606 ink face and
 back, 3/16" Black
 Consecutive Numbers
 Face only, Circles are
 12.7mm ID,
 2" (50.8mm)

Form Name	New Jersey IEM-1a
Design ID	[REDACTED]
Version	[REDACTED]
Design Date	08/09/24 JM

Dotted Magenta lines signify perf lines.

○ ○ ○ Magenta circles signify line holes.

Perf: 3/4"

Folded Flap: 1 1/2"

New Jersey Department of Health
NEWBORN SCREENING LABORATORY
P.O. Box 371
Trenton, NJ 08625-0371

INSTRUCTIONS

Fill in information on form completely. Print clearly in Pen. Press firmly to assure legibility.

1. Hold infant's limb in a dependent position to improve 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. Wipe puncture site with dry swab.
4. Allow large blood droplet to form.
5. Touch filter paper to blood and allow to soak through completely in each circle. Total saturation of circles must be evident when the paper is viewed on both sides. DO NOT APPLY BLOOD TO BOTH SIDES.
6. ALLOW BLOOD SPOTS TO AIR DRY FOR THREE TO FOUR HOURS AT ROOM TEMPERATURE. KEEP AWAY FROM DIRECT SUNLIGHT AND HEAT. NEVER SUPERIMPOSE ONE WET FILTER PAPER ON ANOTHER BEFORE DRYING.
7. When mailing, specimens should not be placed in hermetically sealed mailers (plastic or plasticene envelopes).
8. Submit filter paper cards promptly to the above address, within 24 hours.

NOTE: Specimens may be unsatisfactory if:

- All circles not completely filled.
- Samples oversaturated due to layering of blood or use of capillary tubes.
- Specimen not allowed to dry thoroughly.
- Contaminated.

WARNING:

1. Do not touch sample area.
2. Do not use if damaged.

DO NOT REMOVE THIS COVER FLAP
THIS FLAP IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.
OPEN THIS FLAP TO UNCOVER THE CIRCLES FOR BLOOD COLLECTION AND LEAVE OPEN FOR BLOOD COLLECTION UNCOVER THE CIRCLES AND THE SPECIMEN AND THE SPECIMEN HANDLERS.
BEFORE SUBMITTING, MAKE SURE THE SPOTS ARE COMPLETELY DRY AND THE PROTECTIVE FILTER IS FOLDED OVER THE FOLDED FLAP AND THE SPOTS ARE DRIED BLOOD SPOTS.

BIOHAZARD

Part 6: 32# Buff Ledger (Flap Open)
ID333 Black and Red 185 ink back only,
red square screened at 70%;
11 1/2" (292.1mm)