

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

Dotted Magenta lines signify perf lines.

Front of Form (Flap Folded)

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.

Perf: 3/4"

Folded Flap: 1 1/2"

DO NOT USE THIS FORM AFTER 08/31/2029

BABY'S LAST NAME (PRINT)

SN 24400001

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 to <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>

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

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

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

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Face of Part 1 (copy on face)

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Perf: 3/4"

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BABY'S LAST NAME (PRINT)

SN 24400001

Instructions to Submitter:

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

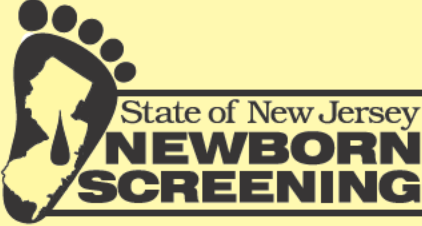
Parents and Legal Guardians,

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State of New Jersey
NEWBORN SCREENING

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

PARENT COPY

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)

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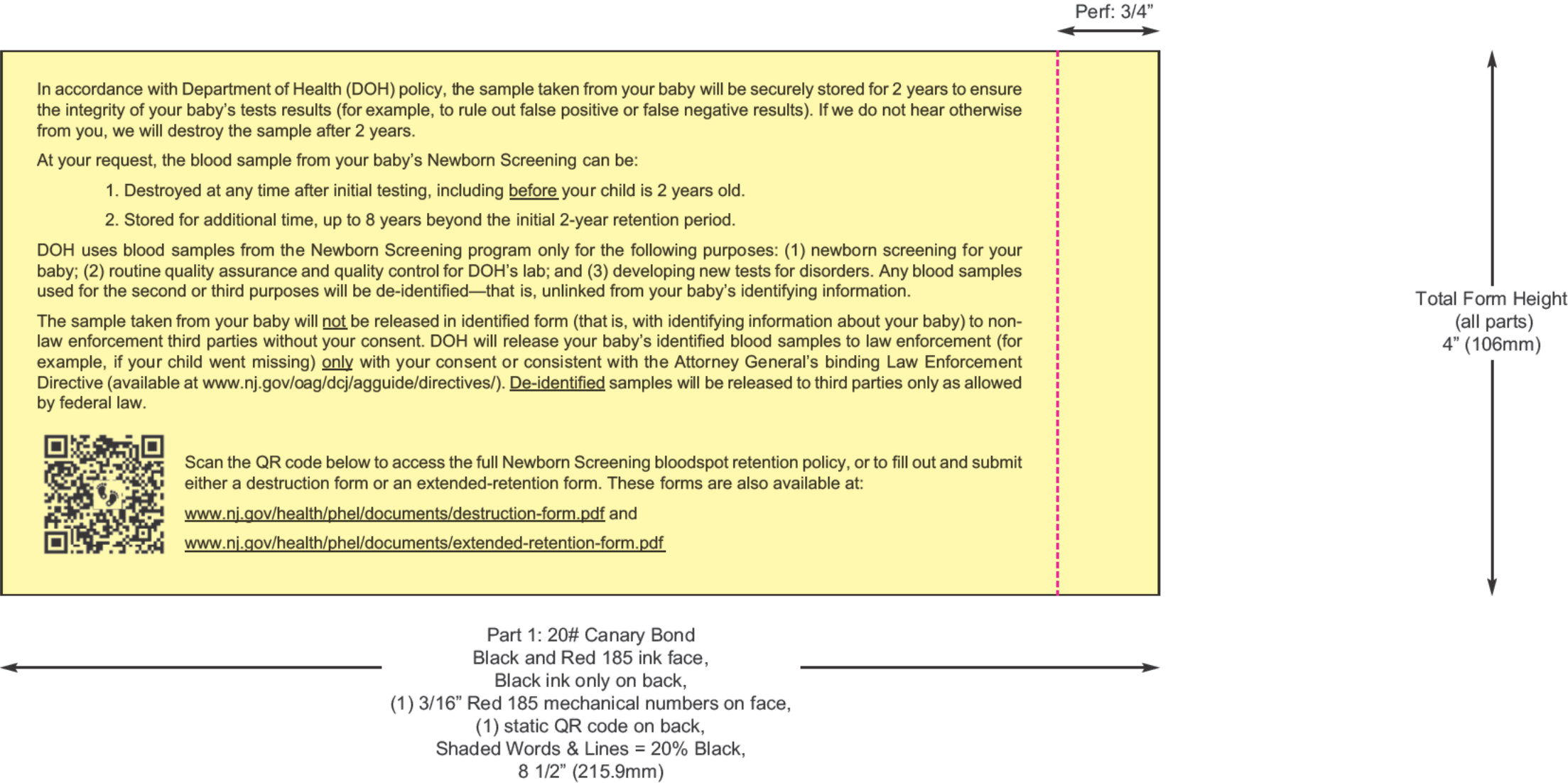
----- Dotted Magenta lines signify perf lines.

Back of Part 1 (copy on face)

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

Manufacturing equivalent substitutions allowed for demographic papers

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Dotted Magenta lines signify perf lines.

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.

Perf: 3/4"

BABY'S LAST NAME (PRINT)			SN 24400001		DO NOT WRITE IN THIS AREA!	
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.			
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						

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
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Dotted Magenta lines signify perf lines.

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.

Perf: 3/4"

BABY'S LAST NAME (PRINT)			SN 24400001		DO NOT WRITE IN THIS AREA		SUBMITTER COPY KEEP THIS COPY FOR YOUR RECORDS		
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.		New Jersey Department of Health REPEAT NEWBORN SCREENING REQUEST				
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)					24400001 SN				
Address		Apt. #							
City, State, Zip		Mother's Telephone No.							
HOSPITAL NAME AND ADDRESS		BABY'S PHYSICIAN NAME AND ADDRESS							
Telephone No.		Telephone No.		Collector's Initials / Date:		STEP 1 FILL OUT INFORMATION ON FORM ACCURATELY AND COMPLETELY			
IEM-1A AUG 24 2029-08-31		SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician		H5783		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			

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

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)

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Face of Parts 4 and 5 (copy on back)
All measurements can vary +/- 1/16" (1.6mm).
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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.

Perf: 3/4"
↔

BABY'S LAST NAME (PRINT)			SN 24400001		DO NOT WRITE IN THIS AREA!	
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)			<div>New Jersey Department of Health</div> <div>REPEAT NEWBORN SCREENING REQUEST</div> <div>24400001</div> <div>SN 24400001</div> <div>24400001</div> <div>Completely fill 5 circles with blood.</div>			
Address Apt. #						
City, State, Zip						
HOSPITAL NAME AND ADDRESS						
Mother's Telephone No.			Collector's Initials / Date:			
BABY'S PHYSICIAN NAME AND ADDRESS			Telephone No.			
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			
LOT 116983 / 30320006 Revity™ 226 Ahlstrom			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: ID0606 ink face and back, (1) 3/16" Black Mechanical Numbers Face only, Circles are 12.7mm ID, 2" (50.8mm) →

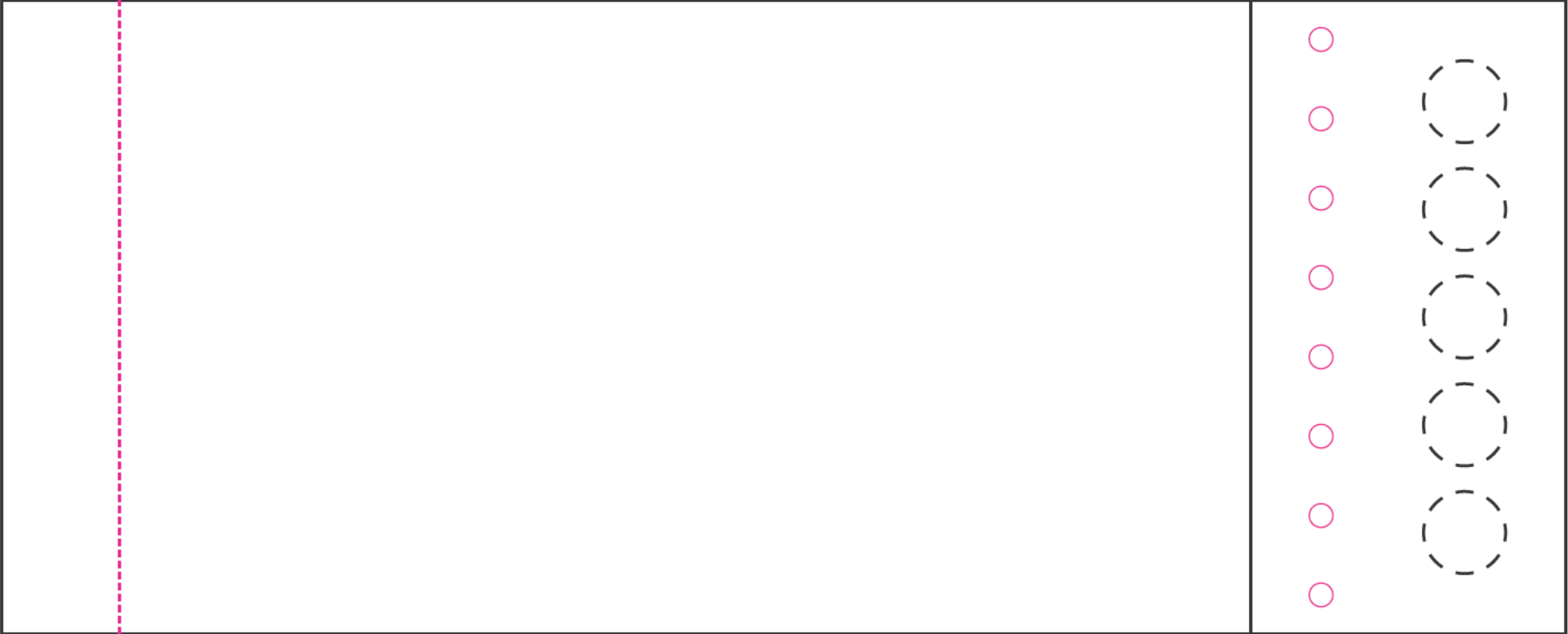


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----- Dotted Magenta lines signify perf lines.

○ ○ ○ Magenta circles signify line holes.

Perf: 3/4"



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

