



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

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.

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

Perf: 3/4"

Folded Flap: 1 1/2"

DO NOT USE THIS FORM AFTER 08/31/2029

BABY'S LAST NAME (PRINT)

SN 24100001

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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| Design ID   |                  |
| Version     |                  |
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Face of Part 1 (copy on back)

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

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Perf: 3/4"

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



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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.

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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/dcj/agguide/directives/](http://www.nj.gov/oag/dcj/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](http://www.nj.gov/health/phel/documents/destruction-form.pdf) and

[www.nj.gov/health/phel/documents/extended-retention-form.pdf](http://www.nj.gov/health/phel/documents/extended-retention-form.pdf)

Perf: 3/4"

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

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

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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.

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

Perf: 3/4"

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| BABY'S LAST NAME (PRINT)  |  |   |  | SN 24100001  |  | DO NOT WRITE IN THIS AREA!   |  |   |  |
| Birth Date  |  | Date of Sample  |  | Type of Feeding<br><input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN<br><input type="checkbox"/> Formula <input type="checkbox"/> Other |  | Antibiotic?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | BABY'S MEDICAL RECORD NO.   |  |
| Birth Time<br><input type="checkbox"/> am <input type="checkbox"/> pm |  | Sample Time<br><input type="checkbox"/> am <input type="checkbox"/> pm        |  | Multiple Birth?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | If Yes, A, B, C, etc.:   |  | Remarks   |  |
| Gender<br><input type="checkbox"/> M <input type="checkbox"/> F       |  | Birthweight<br>gms <input type="checkbox"/> No <input type="checkbox"/> Yes:- |  | RBC Transfused PRIOR to sample collection?<br>If Yes, give date and time:  |  | Gestational Age<br>wks   |  | <div>New Jersey<br/>Department of Health</div> <div>INITIAL<br/>NEWBORN<br/>SCREENING<br/>REQUEST</div> <div>24100001</div> |  |
| MOTHER'S NAME (LAST, FIRST) (PRINT)                                   |  |   |  | Mother's Age   |  |  |  |   |  |
| Address   |  |   |  | Apt. #   |  |  |  |   |  |
| City, State, Zip  |  |   |  | Mother's Race<br>1 <input type="checkbox"/> White<br>2 <input type="checkbox"/> Black or African American<br>3 <input type="checkbox"/> Asian          |  | 4 <input type="checkbox"/> American Indian/ Alaskan Native<br>5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br>8 <input type="checkbox"/> Other |  | Mother's Hispanic Origin<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| HOSPITAL NAME AND ADDRESS   |  |   |  | Mother's Telephone No.   |  | Collector's Initials / Date:   |  |   |  |
| Telephone No.   |  |   |  | BABY'S PHYSICIAN NAME AND ADDRESS  |  | Telephone No.  |  |   |  |
| IEM-1 AUG 24 2029-08-31   |  |   |  | SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician   |  | H5782  |  | 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 number,  
(1) Code 128 barcode with (1) human readable,  
Shaded Words & Lines = 20% Black,  
8 1/2" (215.9mm)



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Face of Parts 4 and 5 (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.

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

Perf: 3/4"

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| BABY'S LAST NAME (PRINT)  |  |  |  | SN 24100001  |  | DO NOT WRITE IN THIS AREA!  |  |  |  |
| Birth Date  |  | Date of Sample   |  | Type of Feeding<br><input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN<br><input type="checkbox"/> Formula <input type="checkbox"/> Other |  | Antibiotic?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | BABY'S MEDICAL RECORD NO.  |  |
| Birth Time<br><input type="checkbox"/> am <input type="checkbox"/> pm |  | Sample Time<br><input type="checkbox"/> am <input type="checkbox"/> pm |  | Multiple Birth?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | If Yes, A, B, C, etc.:  |  | Remarks  |  |
| Gender<br><input type="checkbox"/> M <input type="checkbox"/> F       |  | Birthweight<br>gms   |  | RBC Transfused PRIOR to sample collection?<br>If Yes, give date and time:<br><input type="checkbox"/> No <input type="checkbox"/> Yes-                 |  | Gestational Age<br>wks  |  |  |  |
| MOTHER'S NAME (LAST, FIRST) (PRINT)                                   |  |  |  | Mother's Age   |  |   |  |  |  |
| Address   |  |  |  | Apt. #   |  | Mother's Race<br>1 <input type="checkbox"/> White<br>2 <input type="checkbox"/> Black or African American<br>3 <input type="checkbox"/> Asian |  | 4 <input type="checkbox"/> American Indian/ Alaskan Native<br>5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander<br>8 <input type="checkbox"/> Other |  |
| City, State, Zip  |  |  |  |  |  | Mother's Hispanic Origin<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Collector's Initials / Date:   |  |
| HOSPITAL NAME AND ADDRESS   |  |  |  | BABY'S PHYSICIAN NAME AND ADDRESS  |  |   |  |  |  |
| Telephone No.   |  |  |  | Telephone No.  |  |   |  |  |  |
| IEM-1 AUG 24 Revvity™ 226 Ahlstrom                                    |  |  |  | SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician   |  | H5782   |  |  |  |
| LOT 116983 / 30310006   |  |  |  | 2029-08-31   |  | 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, 3/16" Black mechanical numbers  
Face only, Circles are 12.7mm ID, 2" (50.8mm)

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| Design ID   | ██████████       |
| Version     | ██               |
| Design Date | 08/09/24 JM      |

Back of Parts 4 and 5 (copy on face)

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

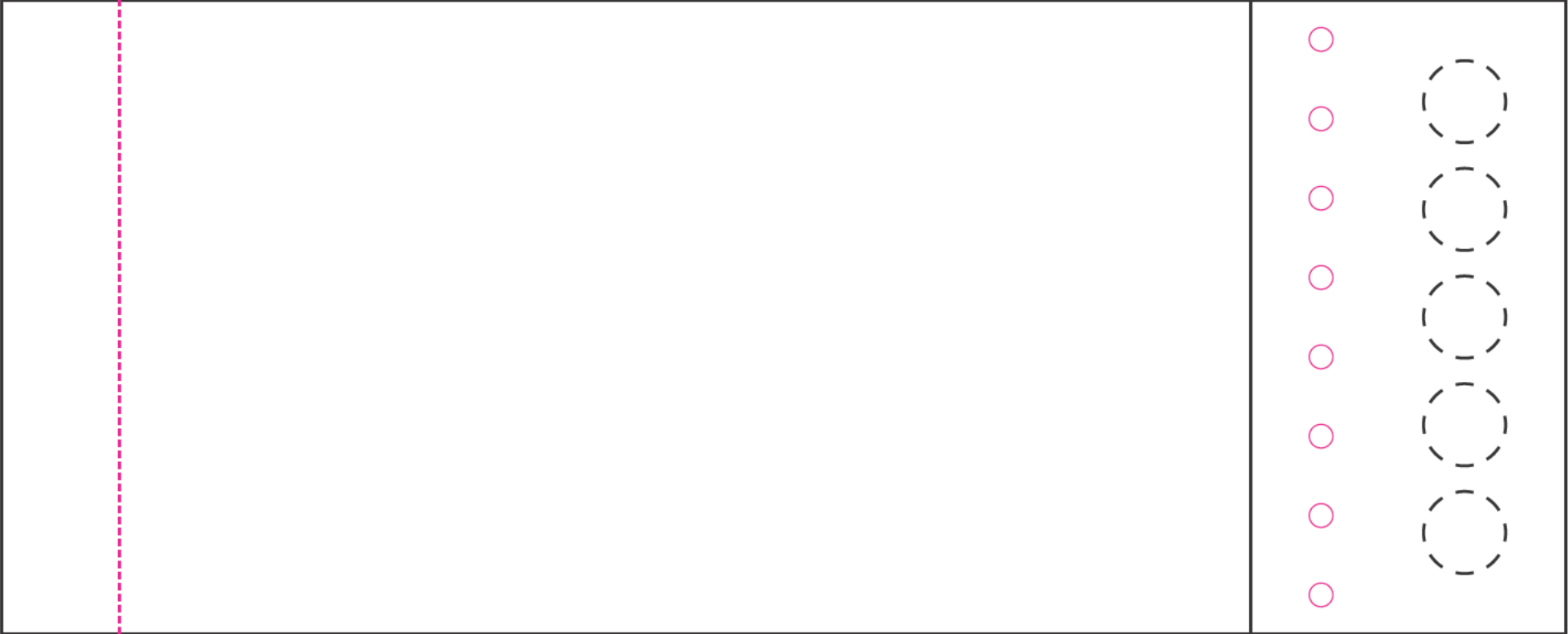
Manufacturing equivalent substitutions allowed for demographic papers

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

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○ ○ ○ 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  
mechanical numbers  
Face only, Circles are  
12.7mm ID,  
2" (50.8mm)





