



# Newborn Screening Dried Bloodspot Collection Form Educational Webinar

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# Presenters

- Ashley Comer, Newborn Screening Quality Improvement Coordinator
- Emily Phillips, Newborn Screening Follow-Up Nurse



**University of Iowa  
Stead Family  
Children's Hospital**



# Redesigned Card

Iowa

Expiration Date 2019-08-31

**Iowa Newborn Screening Program Form**

Initial Screen    Repeat Screen    Collection Date Year Month Day    Collection Time - (24 hour clock)    Collector    Infant's Medical Record #

Infant's Last Name    Infant's First Name

Infant's Birth Date Year Month Day    Infant's Birth Time (24 hour clock)    M    F    Infant's Street Address    Apartment

City    State    Zip Code    If multiple A,B...etc    Gestational Age at Birth   Feeding Method (Check all that apply)    Breast Milk    Formula    TPN    None of the above

Current Weight (g)    Transfused Before Collection Any Blood Products Yes No    If Yes, Date of Last Transfusion Year Month Day    Check if infant is in NICU    Check if infant has Meconium Ileus

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Guardian Mother    Other Please Specify    Guardian's Last Name    Guardian's First Name

Guardian's Birth Date Year Month Day    M    F    Guardian's Phone Number

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Ordering Health Care Provider's Last Name    Ordering Health Care Provider's First Name    Ordering Health Care Provider's Phone Number

Ordering Health Care Provider's NPI

Primary Care Provider's Last Name    Check if same as above    Primary Care Provider's First Name    Primary Care Provider's Phone Number

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Submitting Facility's Name    Submitting Facility's Street Address    City    State    Zip Code

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

DO NOT WRITE IN THIS SPACE

FOR SHL USE ONLY

\*IAXXXXXXXX\*

**DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.**

**PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY**

**AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.**

- 1) Do not touch sample area
- 2) Do not use if damaged

BIOHAZARD

- Overall appearance similar to current card.
- Additional fields added and arrangement of fields altered.

# Education

- Before a newborn screen is obtained a parent or guardian should be educated on
  - the type of specimen
  - how it is obtained
  - disorders screened for
  - consequences of treatment and non treatment
  - Retention, use, and disposition of residual specimens



Iowa Newborn Screening Program  
brochures are available at 1-800-369-2229

**Newborn screening educational resources are available to assist in education.**

One Foot at a Time Video <http://savebabies.org/video.html>

# It's not just a form...It's a baby

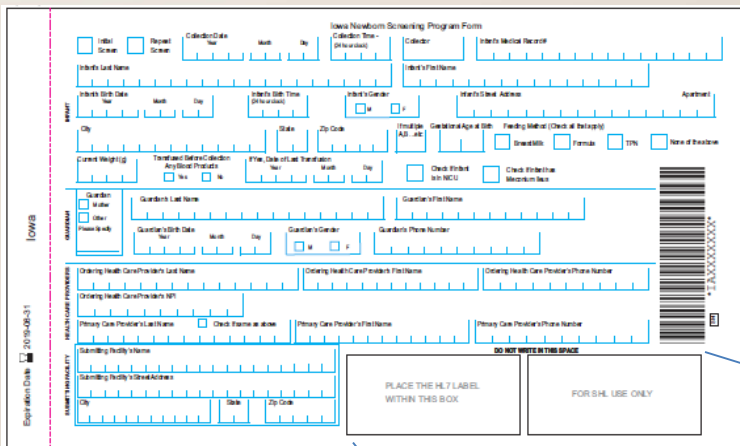
- Filling out the newborn screening form...
  - ✓ Accurately
  - ✓ Completely
  - ✓ LegiblyCould be a matter of life and death
- Inaccurate or missing information may adversely affect screening results and/or the ability to quickly contact the infant's care provider in the event of an abnormal screening result.
- *Any delay may put the child's health at risk.*
- The specimen submitter is legally responsible for the accuracy and completeness of the information on the newborn screening card.



Remember to remove 2<sup>nd</sup> ply for facility's records.

# Health Level 7 (HL7)

- Placement of HL7 sticker has changed



Iowa Newborn Screening Program Form

Infant Screen:  Initial Screen  Repeat Screen

Collection Date: \_\_\_\_\_

Collection Time: \_\_\_\_\_

Infant's Last Name: \_\_\_\_\_

Infant's Birth Date: \_\_\_\_\_

Infant's Birth Time (24-hour): \_\_\_\_\_

Infant's Gender:  M  F

Infant's Street Address: \_\_\_\_\_

Apartment: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Insurance:  Medicaid  Private

Current Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Head Circumference: \_\_\_\_\_

Any Blood Products:  Yes  No

Other Data or Lab Test: \_\_\_\_\_

Check Infant with NICU:  Yes  No

Check Infant with NICU:  Yes  No

Check Infant with NICU:  Yes  No

Guardian's Last Name: \_\_\_\_\_

Guardian's Birth Date: \_\_\_\_\_

Guardian's Gender:  M  F

Guardian's Phone Number: \_\_\_\_\_

Ordering Health Care Provider's Last Name: \_\_\_\_\_

Ordering Health Care Provider's Phone Number: \_\_\_\_\_

Ordering Health Care Provider's HPI: \_\_\_\_\_

Primary Care Provider's Last Name: \_\_\_\_\_

Primary Care Provider's Phone Number: \_\_\_\_\_

Standing Facility Name: \_\_\_\_\_

City: \_\_\_\_\_

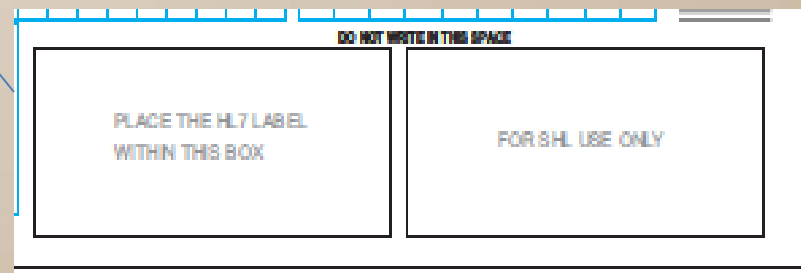
State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY



DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY

- Please do not write in the box "FOR SHL USE ONLY"

# Sample Information

Iowa Newborn Screening Program Form

Initial Screen   
  Repeat Screen   
 Collection Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_   
 Collection Time - (24 hour clock) \_\_\_\_\_   
 Collector \_\_\_\_\_

Iowa Newborn Screening Program Form

Initial Screen   
 Repeat Screen   
 Collection Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_   
 Collection Time - (24 hour clock) \_\_\_\_\_   
 Collector \_\_\_\_\_   
 Infant's Medical Record # \_\_\_\_\_

Infant's Last Name \_\_\_\_\_   
 Infant's First Name \_\_\_\_\_

Infant's Birth Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_   
 Infant's Birth Time (24-hour clock) \_\_\_\_\_   
 Infant's Gender:  M  F

Infant's Street Address \_\_\_\_\_   
 Apartment \_\_\_\_\_

City \_\_\_\_\_   
 State \_\_\_\_\_   
 Zip Code \_\_\_\_\_   
 Feeding Method (Check all that apply):  Breast Milk   
 Formula   
 TPN   
 None of the above

Current Weight (g) \_\_\_\_\_   
 Transfused Before Collection:  Yes   
 No   
 If Yes, Date of Last Transfusion: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Check if infant is in NICU   
 Check if infant has Meconium Ileus

**GUARDIAN**  
 Mother   
 Other Please Specify \_\_\_\_\_   
 Guardian's Last Name \_\_\_\_\_   
 Guardian's First Name \_\_\_\_\_

Guardian's Birth Date: Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_   
 Guardian's Gender:  M  F   
 Guardian's Phone Number \_\_\_\_\_

**HEALTH CARE PROVIDER**  
 Ordering Health Care Provider's Last Name \_\_\_\_\_   
 Ordering Health Care Provider's First Name \_\_\_\_\_   
 Ordering Health Care Provider's Phone Number \_\_\_\_\_

Ordering Health Care Provider's NPI \_\_\_\_\_

Primary Care Provider's Last Name \_\_\_\_\_   
 Check if same as above   
 Primary Care Provider's First Name \_\_\_\_\_   
 Primary Care Provider's Phone Number \_\_\_\_\_

**SUBMITTING FACILITY**  
 Submitting Facility's Name \_\_\_\_\_   
 Submitting Facility's Street Address \_\_\_\_\_   
 City \_\_\_\_\_   
 State \_\_\_\_\_   
 Zip Code \_\_\_\_\_

Expiration Date: 2019-08-31

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY

## Changes

- Collection information moved to top of form
- Collection date format YYYY MM DD

Initial Screen= 1<sup>st</sup> submission

Repeat Screen= Any subsequent submissions received after the initial screen, even if 1<sup>st</sup> submission was rejected due to poor quality, early collection, etc.

# Infant Information

**Infant's Medical Record #**

**Infant's Last Name**

**Infant's First Name**

**Infant's Birth Date** Year Month Day

**Infant's Birth Time** (24 hour clock)

**Infant's Gender**  M  F

**Infant's Street Address**

**Apartment**

**City**

**State**

**Zip Code**

**If multiple A,B ...etc**

**Gestational Age at Birth**

**Feeding Method (Check all that apply)**


Breast Milk  Formula  TPN  None of the above

**Current Weight (g)**

**Transfused Before Collection Any Blood Products**  Yes  No

**If Yes, Date of Last Transfusion** Year Month Day

Check if infant is in NICU  Check if infant has Meconium Ileus



**Iowa Newborn Screening Program Form**

Initial Screen  Repeat Screen  Collection Date Year Month Day

**Infant's Last Name**

**Infant's First Name**

**Infant's Birth Date** Year Month Day

**Infant's Birth Time** (24 hour clock)

**Infant's Gender**  M  F

**Infant's Street Address**

**Apartment**

**City**

**State**

**Zip Code**

**If multiple A,B ...etc**

**Gestational Age at Birth**

**Feeding Method (Check all that apply)**

Breast Milk  Formula  TPN  None of the above

**Current Weight (g)**

**Transfused Before Collection Any Blood Products**  Yes  No

**If Yes, Date of Last Transfusion** Year Month Day

Check if infant is in NICU  Check if infant has Meconium Ileus

**Guardian's Last Name**

**Guardian's First Name**

**Guardian's Birth Date** Year Month Day

**Guardian's Gender**  M  F

**Guardian's Phone Number**

**Obstetric Health Care Provider's Last Name**

**Obstetric Health Care Provider's First Name**

**Obstetric Health Care Provider's Phone Number**

**Primary Care Provider's Last Name**  Check if same as above **Primary Care Provider's First Name**

**Primary Care Provider's Phone Number**

**Submitting Facility's Name**

**Submitting Facility's Street Address**

**City**

**State**

**Zip Code**

**DO NOT WRITE IN THIS SPACE**

**PLACEMENT OF HL7 LABEL WITHIN THIS BOX**

**FOR SHL USE ONLY**

**Expiration Date: 2/18/2031**

**Barcode**

## Changes

- Current card uses the term “chart number” and new form uses MRN
- DOB format YYYY/MM/DD



# Infant Information continued

Infant's Medical Record #

Infant's Last Name

Infant's First Name

Infant's Birth Date: Year, Month, Day

Infant's Birth Time (24 hour clock)

Infant's Gender:  M  F

Infant's Street Address

Apartment

City

State

Zip Code

If multiple A,B...etc

Gestational Age at Birth

Feeding Method (Check all that apply):  Breast Milk  Formula  TPN  None of the above


Current Weight (g)

Transfused Before Collection Any Blood Products:  Yes  No

If Yes, Date of Last Transfusion: Year, Month, Day

Check if infant is in NICU

Check if infant has Meconium Ileus



Iowa Newborn Screening Program Form

Initial Screen  Repeat Screen

Infant's Last Name

Infant's First Name

Infant's Birth Date: Year, Month, Day

Infant's Birth Time (24 hour clock)

Infant's Gender:  M  F

Infant's Street Address

Apartment

City

State

Zip Code

If multiple A,B...etc

Gestational Age at Birth

Feeding Method (Check all that apply):  Breast Milk  Formula  TPN  None of the above

Current Weight (g)

Transfused Before Collection Any Blood Products:  Yes  No

If Yes, Date of Last Transfusion: Year, Month, Day

Check if infant is in NICU

Check if infant has Meconium Ileus

Guardian's Last Name

Guardian's First Name

Guardian's Birth Date: Year, Month, Day

Guardian's Gender:  M  F

Guardian's Phone Number

Ordering Health Care Provider's Last Name

Ordering Health Care Provider's First Name

Ordering Health Care Provider's Phone Number

Primary Care Provider's Last Name

Primary Care Provider's First Name

Primary Care Provider's Phone Number

Submitting Facility's Name

Submitting Facility's Street Address

City

State


Zip Code

Expiration Date: 2/18/2031

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL WITHIN THIS BOX

FOR SHL USE ONLY



## Changes

- Infant's street address
- List multiple births using A,B,C etc
- Only applicable for this pregnancy





# Submitter Information

**SUBMITTING FACILITY**

Submitting Facility's Name

Submitting Facility's Street Address

City State Zip Code

Iowa Newborn Screening Program Form

Initial Screen  Repeat Screen  Collection Date Year Month Day

Submitter's Last Name Submitter's First Name Submitter's Middle Name

Submitter's Birth Date Year Month Day Submitter's Sex Male Female Submitter's Street Address Apartment

City State Zip Code

Current Weight in Pounds Ounces

Guardian's Last Name Guardian's First Name Guardian's Middle Name

Ordering Health Care Provider's Last Name Ordering Health Care Provider's First Name Ordering Health Care Provider's Street Number

Submitting Facility Name Submitting Facility's Street Address City State Zip Code

PLACEMENT OF THE HELP LABEL WITHIN THIS BOX

FOR SHL USE ONLY

## Changes

- Facility ID's are changing in our new LIMS system so this field was removed.
- Pre-printed label with submitter name and address will be provided with forms instead to accurately identify submitter.

(1)

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_, IA

# Guardian Information

<b>GUARDIAN</b>	<input type="checkbox"/> Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Other Please Specify _____	Guardian's Last Name		Guardian's First Name						
		Guardian's Birth Date		Guardian's Gender		Guardian's Phone Number				
		Year	Month	Day	<input type="checkbox"/> M	<input type="checkbox"/> F				

The screenshot shows the 'Iowa Newborn Screening Program Form' with the 'GUARDIAN' section highlighted. The form includes fields for infant information (name, birth date, gender, address, weight, etc.) and guardian information (name, birth date, gender, phone number, and address). A barcode is visible on the right side of the form.

## Changes

- Changed section from Mother to Guardian.
  - **If biological mother is the legal guardian, please provide her information.**
- Added Box to determine relation to infant: Mother or Other Guardian

# Health Care Provider Information

**HEALTH CARE PROVIDERS**

Ordering Health Care Provider's Last Name	Ordering Health Care Provider's First Name	Ordering Health Care Provider's Phone Number
Ordering Health Care Provider's NPI		
Primary Care Provider's Last Name <input type="checkbox"/> Check if same as above	Primary Care Provider's First Name	Primary Care Provider's Phone Number

## Changes

- Fields for both Ordering Health Care Provider AND Primary Care Provider
- Ordering Health Care Provider Number (NPI)

<https://npiregistry.cms.hhs.gov/>

# Health Care Provider Information


HEALTH CARE PROVIDERS	Ordering Health Care Provider's Last Name	Ordering Health Care Provider's First Name	Ordering Health Care Provider's Phone Number
	Ordering Health Care Provider's NPI		
	Primary Care Provider's Last Name <input type="checkbox"/> Check if same as above	Primary Care Provider's First Name	Primary Care Provider's Phone Number

**The NBS program requests PCP information if known at time of collection.**  
 During education to parents about newborn screening or before the sample is collected please ask the guardian who or where they plan on taking newborn for first well check visit.





# Refusals

 **Refusal of Iowa Newborn Blood Spot Screening**  
Iowa Department of Public Health

DATE OF BIRTH: \_\_\_\_\_ TIME OF BIRTH: \_\_\_\_\_

INFANT'S ADDRESS: \_\_\_\_\_

PARENT'S ADDRESS: \_\_\_\_\_

PARENT'S PHONE NUMBER home or cell (circle one) \_\_\_\_\_ PARENT'S EMAIL ADDRESS: \_\_\_\_\_

PLACE OF BIRTH (FACILITY NAME): \_\_\_\_\_

ATTENDING BIRTH CARE PROVIDER AT BIRTH: \_\_\_\_\_

PROVIDER WHO WILL BE OVERSEEING BABY'S WELL-BABY CHECKS: \_\_\_\_\_

I have received and read the parent informational brochure which describes the newborn screening tests currently being performed in the state of Iowa. I understand that these disorders are easily detected by testing a blood sample from my baby's heel.

I have been informed and I understand that it is the law of the state of Iowa that all newborns shall be screened for these disorders.

I have been informed and I understand that this screening is done to detect these disorders because symptoms sometimes do not appear for several days, weeks or months.

I have been informed and understand that, if untreated, these conditions may cause permanent damage to my child, including intellectual disability (mental retardation), growth failure, and death.

I have discussed this screening with \_\_\_\_\_ (BIRTH CARE PROVIDER)

and I understand the risks to my child if this screening is not completed.

My decision is made freely and I accept the legal responsibility for the consequences of this decision.

Reason for refusal:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Return to:  
State Hygienic Laboratory c/o NBS Follow-up Program  
Email: [iowanewbornscreening@iowa.edu](mailto:iowanewbornscreening@iowa.edu)  
Fax 319-384-5116

I hereby release, waive, discharge, and covenant not to sue \_\_\_\_\_ (NAME OF HOSPITAL OR BIRTH CARE PROVIDER)

the Iowa Department of Public Health, the State of Iowa, and all employees, officials, staff, agents, and volunteers of these entities and agencies for any liability, claim, and/or cause of action arising out of my refusal to allow my child's birth care provider to conduct newborn metabolic screening on my baby or arising out of any loss, damage, injury, or illness that occurs as a result of the fact that my baby was not screened for the congenital disorders available in the testing panel.

\_\_\_\_\_  
SIGNATURE PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME OF PARENT OR LEGAL GUARDIAN

Return to:  
State Hygienic Laboratory c/o NBS Follow-up Program  
Email: [iowanewbornscreening@iowa.edu](mailto:iowanewbornscreening@iowa.edu)  
Fax 319-384-5116

<https://idph.iowa.gov/genetics/provider/newborn-screening>







# Contact Information

- Data entry questions or corrections:
  - State Hygienic Laboratory at 515-725-1630
- To order forms or collection supplies:
  - State Hygienic Laboratory at 515-725-1630
- Follow-up recommendations or refusals:
  - NBS Follow-up clinical staff at 319-384-5097 or toll free 1-866-890-5965
- Program and Policy questions:
  - Kim Piper at 1-800-383-3826