


Filling out the newborn screening filter paper completely and accurately is an important part of specimen collection. Each field is used by laboratory and follow up staff to determine cutoff values, aid in interpretation of results, and to perform follow up activities.

How the Newborn Screening (NBS) Program Uses Each Field:

- **Hospital of birth/hospital of transfer:** Used for identification and billing purposes. This also ensures that your facility receives a copy of the NBS report. Checking the submitter box helps us know who to send the report to in the event the baby is transferred or receives a subsequent screen as an outpatient.
- **Medical record number:** Essential for identification purposes, particularly if there are two babies with the same name or multiple births. Needed for identification if the legal name changes after discharge.
- **Birth parent's demographic information:** If follow up needs to occur and no medical home is established, newborn screening staff will use this information to contact the parent directly. The name placed here will also be displayed on the NBS report. If the individual who gave birth to the baby should not have their information in the client record per your institution's policies, please leave this field blank and put the legal parent's contact information in the comments box and check the associated box.
- **Birth parent's thyroid history/medications:** If it is indicated that the birth parent has thyroid disease or was taking thyroid medication, then TSH will be tested in addition to T4.
- **Baby's provider:** NBS staff need to know who to contact for abnormal results and where to send the NBS report to after discharge.
- **Baby's name:** Used for identification purposes.
- **Baby's sex:** Used for identification purposes. Also used for risk-assessment in certain NBS conditions.
- **Single or multiple birth and ordinance:** Same-sex multiples are screened by a slightly different algorithm. This is also used for identification purposes.
- **Date/time of birth:** Used for identification purposes and to determine whether a specimen is timed appropriately. Most lab tests have age-based cutoffs. Please use 24-hour time (military time) only.
- **Date/time of specimen collection:** Used to determine whether a specimen is timed appropriately. Most lab tests have age-based cutoffs. Please use 24-hour time (military time) only.
- **Gestational age:** Premature babies are screened using slightly different algorithms. This also assists with interpretation of abnormal results.
- **Birth weight and current weight:** Low birth weight babies are screened using different algorithms. Cutoff values for many newborn screening tests are weight dependent.

- **Has this baby received blood products <48 hrs. prior to specimen collection:** If a specimen is collected <48 hrs. after receipt of blood products it will be called unsatisfactory for testing and will need to be repeated.
- **Has this baby ever received blood products:** Assists with interpretation of hemoglobinopathy results.
- **Has this baby been on TPN in the last 48 hrs.:** Assists with interpretation of metabolic results.
- **Date of last transfusion:** Helps follow up staff determine when a repeat may be indicated and aids in interpretation of hemoglobinopathy results.
- **Is this baby in NICU:** Testing algorithms and protocols differ for babies in NICU. TSH is run in addition to T4 for all NICU specimens. Alerts NBS follow up staff that NICU will be main contact for follow up.
- **Location of specimen collection:** Helps NBS staff determine where to send the NBS report and who to follow up with if essential information is missing or there are problems with specimen quality.
- **Check box if parent/guardian is different than birth parent:** If the birth parent will not be the baby's legal parent/guardian, please provide contact information for the person caring for the baby in the event follow up is required.
- **Submitter's initials:** Helpful if there are ongoing quality issues or questions related to the collection of a specimen.

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| <p>VT 2023 2028-04-30</p> | <input type="checkbox"/> FIRST SPECIMEN <input type="checkbox"/> REPEAT SPECIMEN | |  | | 2028-04-30 VERMONT 2023 ORIGINAL COPY | |
| | HOSPITAL OF BIRTH (NAME or CODE) | | CHECK IF SUBMITTER | | SN VT513001 <small>FOR LIST OF CONDITIONS SCREENED, CONTACT VT NEWBORN SCREENING PROGRAM AT (802) 951-5180</small> | |
| | BABY'S MEDICAL RECORD NO. | | HOSPITAL OF TRANSFER (NAME or CODE) | | BABY'S NAME (LAST) (FIRST) | |
| | BIRTH PARENT'S NAME (LAST) | | | | BIRTH PARENT'S BIRTH DATE | |
| | BIRTH PARENT'S NAME (FIRST) | | | | SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | |
| | STREET AND MAILING ADDRESS | | | | BIRTH DATE <u> </u> / <u> </u> / <u> </u> yr TIME: <u> </u> : <u> </u> : <u> </u> IS BABY IN NICU? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | CITY/TOWN STATE ZIP | | SPECIMEN DATE <u> </u> / <u> </u> / <u> </u> yr TIME: <u> </u> : <u> </u> : <u> </u> | | | |
| | HOME TEL () CELL () | | GESTATIONAL AGE _____ weeks _____ days | | | |
| | BIRTH PARENT'S MEDICAL HISTORY THYROID DISEASE? <input type="checkbox"/> YES THYROID MEDS DURING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | BIRTH WEIGHT _____ grams _____ OR lbs/oz _____ / CURRENT WEIGHT _____ grams _____ OR lbs/oz _____ / | |
| | BABY'S DOCTOR (NAME or CODE) | | CHECK IF SUBMITTER | | IS THIS BABY LESS THAN 24 HOURS OLD? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS THIS BABY REC'D BLOOD PRODUCTS IN LAST 48 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS THIS BABY EVER REC'D BLOOD PRODUCTS? <input type="checkbox"/> YES <input type="checkbox"/> NO HAS BABY BEEN ON TPN IN LAST 48 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| STREET (P.O. BOX) | | | | DATE OF LAST TRANSFUSION <u> </u> / <u> </u> / <u> </u> yr | | |
| CITY/TOWN STATE ZIP | | SAMPLE COLLECTED IN: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DR.'S OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> OTHER | | | | |
| TELEPHONE () | | | | <input type="checkbox"/> IF BIRTH PARENT IS NOT LEGAL GUARDIAN, PLEASE CHECK BOX. WRITE LEGAL GUARDIAN NAME AND CONTACT INFORMATION IN COMMENT SECTION. | | |
| IF HOME BIRTH, MIDWIFE'S NAME (NAME or CODE): | | CHECK IF SUBMITTER | | COLLECTOR'S INITIALS COMMENTS: | | |
| MIDWIFE'S ADDRESS | | | | | | |

THIS AREA FOR SCREENING LABORATORY USE ONLY