


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.
- **Legal parent/guardian demographic information:** If follow up needs to occur and no medical home is established, newborn screening staff will use this information to contact the person caring for the baby directly. *The name placed here will also be displayed on the NBS report.* Only one parent/guardian needs to be listed.
- **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.
- **Pediatrician/Primary Care Provider:** NBS staff need to know who to contact for abnormal results and where to send the NBS report to after discharge. Please list the practice name and contact information instead of the individual provider (unless solo practice or midwife).
- **Baby's legal name:** Used for identification purposes. If legal name not known please use name at the time of birth.
- **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.
- **Submitter's initials:** Helpful if there are ongoing quality issues or questions related to the collection of a specimen.

VT 2024 2029-04-30	<input type="checkbox"/> FIRST SPECIMEN <input type="checkbox"/> REPEAT SPECIMEN		HOSPITAL OF BIRTH <input type="checkbox"/> CHECK IF SUBMITTER		 SN VT523001	2029-04-30 VERMONT 2024 ORIGINAL COPY
	BABY'S MEDICAL RECORD NO. HOSPITAL OF TRANSFER <input type="checkbox"/> CHECK IF SUBMITTER		FOR LIST OF CONDITIONS SCREENED, CONTACT VT NEWBORN SCREENING PROGRAM AT (802) 951-5180			
	LEGAL PARENT'S NAME (LAST) _____		BABY'S NAME (LAST, FIRST – PLEASE USE LEGAL NAME IF KNOWN) _____		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	
	LEGAL PARENT'S NAME (FIRST) _____ LEGAL PARENT'S BIRTH DATE _____		BIRTH DATE <input type="text"/> / <input type="text"/> / <input type="text"/> yr. TIME <input type="text"/> : <input type="text"/> : <input type="text"/> <small>military time only</small>		IS BABY IN NICU? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	STREET AND MAILING ADDRESS _____		SPECIMEN DATE <input type="text"/> / <input type="text"/> / <input type="text"/> yr. TIME <input type="text"/> : <input type="text"/> : <input type="text"/> <small>military time only</small>		GESTATIONAL AGE _____ weeks _____ days	
	CITY/TOWN _____ STATE _____ ZIP _____		BIRTH WEIGHT _____ grams _____ OR lbs/oz _____ / _____		CURRENT WEIGHT _____ grams _____ OR lbs/oz _____ / _____	
	HOME TEL () _____ CELL () _____		BIRTH PARENT'S MEDICAL HISTORY _____ BIRTH PARENT'S DOB <input type="text"/> / <input type="text"/> / <input type="text"/> yr.		HAS THIS BABY REC'D BLOOD PRODUCTS IN LAST 48 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	THYROID DISEASE? <input type="checkbox"/> YES THYROID MEDS DURING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRACTICE NAME OF BABY'S PROVIDER _____ <input type="checkbox"/> CHECK IF SUBMITTER		HAS THIS BABY EVER REC'D BLOOD PRODUCTS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	STREET (P.O. BOX) _____		CITY/TOWN _____ STATE _____ ZIP _____		HAS BABY BEEN ON TPN IN LAST 48 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
	TELEPHONE () _____		IF HOME BIRTH, MIDWIFE'S NAME: _____ <input type="checkbox"/> CHECK IF SUBMITTER		DATE OF LAST TRANSFUSION <input type="text"/> / <input type="text"/> / <input type="text"/> yr.	
MIDWIFE'S ADDRESS _____		SAMPLE COLLECTED IN: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> PCP'S OFFICE <input type="checkbox"/> HOME <input type="checkbox"/> OTHER _____		COLLECTOR'S INITIALS _____ COMMENTS: _____		

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