

I-32 Specimen Not Obtained Section

WHAT DO I DO?

The new I-32 million series Test Request Form (TRF) has an updated section for any specimen not obtained. This section replaces the NBS-NO form and NBS-TR form.

SPECIMEN NOT OBTAINED

If a specimen is not obtained, mark the Reason in the SPECIMEN NOT OBTAINED field. Please read below for additional instructions for each Specimen Not Obtained reason:

● URGENT TRANSFER

If the baby is >12 hours of age, please collect the NBS specimen before transfer. If the baby is <12 hours of age, write in the COMMENTS section the name of the receiving hospital. Keep the yellow copy in the baby's chart. Make a copy of the TRF and give it to the receiving hospital. Be certain they know that the NBS needs to be collected. Give the pink copy and blue page to the parents.

● REFUSED

If the family is refusing the newborn screen, please have the parent sign on the signature line and write the date in the space provided.

If the family is refusing to sign, a witness should write:

- (1) on the signature line - Parents refused to sign + the date AND
- (2) in the comments box - Witness first and last name, Witness

● EXPIRED

Specify in the COMMENTS section the date, time, and cause of death.

● OTHER

Specify in the COMMENTS section any other reason why the specimen was not obtained before discharge.

Complete TRF with all of the information required, add to the Newborn Screening Transport Log, and send TRF without blood to the screening lab with routine screens. Do NOT mail to the California Newborn Screening Program.

NBS COPY

CALIFORNIA NEWBORN SCREENING TEST REQUEST FORM (TRF)
State of California - Department of Public Health
Health and Human Services Agency

FOR STATE USE ONLY

32 093 835 64

LABEL/ADDRESSOGRAPH HERE

BABY'S INFORMATION

BABY'S LAST NAME	PLEASE PRINT USING ALL CAPITAL LETTERS	DATE OF BIRTH	BIRTH HOUR
FIRST NAME		M M D D Y Y	1 2 4 H R
STREET ADDRESS		GESTATIONAL AGE	SEX
CITY		WEEKS	MALE FEMALE
MEDICAL RECORD/HR #		HOSPITAL ORDER #	
		H L T	U S E

NEWBORN ON PN/HYPERALB
OR AMINO ACID AT TIME OF
COLLECTION: ONLY HUMAN MILK
 ONLY FORMULA
 HUMAN MILK & FORMULA
 NO YES

ALL FEEDINGS SINCE BIRTH: (Circle One) NICU / PICU
 REG NURSERY / FCC / RI
 HOME BIRTH
 OUTPATIENT

RACE/ETHNICITY: FILL ALL THAT APPLY

WHITE	CHINESE	VIETNAMESE	OTHER S.E. ASIAN	MIDDLE EASTERN	HAWAIIAN	SAMOAN
HISPANIC	OPANES	CAMBODIAN	ASIAN INDIAN	GUAMANIAN	NAKAN	NATIVE AMERICAN
BLACK	KOREAN	LAOTIAN (LAOS)	OTHER (Specify)			

MOTHER'S INFORMATION/LEGAL GUARDIAN INFORMATION

MOTHER'S LAST NAME	M M D D Y Y	MOTHER'S BIRTH DATE
FIRST NAME		MOTHER'S SSN LAST 4 DIGITS
MAIDEN NAME		
MOM-IPH-ONE	ALTERNATE/EMERGENCY	

PRIMARY LANGUAGE (Fill only ONE circle): ENGLISH OTHER (Specify):

FACILITY/SUBMITTER DRAWING SPECIMEN:

FACILITY/NAME	HOSPITAL/SUBMITTER CODE	INITIALS OF COLLECTOR
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INPATIENT/ORDERING PHYSICIAN/PROVIDER:

LAST NAME	FIRST NAME
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DATE SPECIMEN COLLECTED: TIME: IF COLLECTED AT <12 HRS OF AGE, REASON: TO BE TRANSFUSED OTHER (Specify):
M M D D Y Y 1 2 4 H R

TYPE OF SPECIMEN: HEELSTICK OTHER (Specify):

RBC TRANSFUSION BEFORE COLLECTION: NO YES - If YES, listetime last transfusion completed: M M D D Y Y 1 2 4 H R

SPECIMEN NOT OBTAINED (If not collected specify why):
 URGENT TRANSFER (Specify receiving hospital in comments)
 EXPIRED OTHER (Specify in comments)
 TEST REFUSAL (Parent's religious beliefs or practices) M M D D Y Y

REASON FOR TEST: (Fill only ONE circle):
 REPEAT OF INEQUATE OR EARLY (<12 HRS) INITIAL SPECIMEN
 OTHER REPEAT (Specify in comments)

COMMENTS:

I REFUSE THE NEWBORN SCREENING TEST ON MY INFANT FOR RELIGIOUS REASONS. I ACCEPT ALL RESPONSIBILITY AND LIABILITY.

NEWBORN'S OUTPATIENT PHYSICIAN INFORMATION (COMMUNITY PRIMARY CARE PROVIDER)

NP/PA #	OR/LLC	HY-PH-O-N-E
PHYSICIAN/LANC	LAST NAME	
FIRST NAME		
STREET ADDRESS	SUITE	
CITY	ZIP	

PLEASE SEE PRIVACY NOTIFICATION WITHIN
To reorder, request form NBS-TRF from the Genetic Disease Screening Program, 903™ LOT 7102718 REF 10534790 EXPIRATION DATE 03/31/2021

* SEND TRF WITHOUT BLOOD TO SCREENING LAB
FOR ANY SPECIMEN NOT OBTAINED *

CDPH USE ONLY

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING
PLACE ACCESSION BARCODE HERE**

32 093 835 64

NBS FORM #

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TRF COPIES



SCREENING LAB



BABY'S CHART



PARENT COPY



Newborn Screening Area Service Center designation and funding provided by the California Department of Public Health Genetic Disease Screening Program www.cdph.ca.gov/nbs

Questions? Contact the Newborn Screening Program at Harbor-UCLA
(310) 222-3751

