

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

LABEL/ADDRESSOGRAPH HERE

NBS FORM # 32 093 835 64

BABY'S INFORMATION PLEASE PRINT USING ALL CAPITAL LETTERS

DATE OF BIRTH BIRTH HOUR

FIRST NAME LAST NAME BIRTHWEIGHT GESTATIONAL AGE SEX BIRTH ORDER IF A.B. MULTIPLE C.B.

STREET ADDRESS APT CITY STATE ZIP

MEDICAL RECORD/EHR # HOSPITAL ORDER #

NEWBORN ON TPN/HYPHERAL OR AMINO ACID AT TIME OF COLLECTION? YES NO

ALL FEEDINGS SINCE BIRTH: (Circle One)

ONLY HUMAN MILK ONLY FORMULA HUMAN MILK & FORMULA NPO

NURSERY TYPE: NICU / PICU REG. NURSERY / FIC / RI HOME BIRTH OUTPATIENT

RACE/ETHNICITY: FILL ALL THAT APPLY

WHITE CHINESE VIETNAMESE OTHER S.E. ASIAN MIDDLE EASTERN HAWAIIAN SAMOAN

HISPANIC JAPANESE CAMBODIAN FILIPINO ASIAN INDIAN GUAMANIAN NATIVE AMERICAN

BLACK KOREAN LAOTIAN (LAOS) OTHER (Specify)

MOTHER'S INFORMATION/LEGAL GUARDIAN INFORMATION

MOTHER'S BIRTH DATE

FIRST NAME LAST NAME MOTHER'S SSN: LAST 4 DIGITS

MAIDEN NAME

PHONE ALTERNATE/EMERGENCY # PHONE

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

FACILITY/SUBMITTER DRAWING SPECIMEN: HOSPITAL/SUBMITTER CODE INITIALS OF COLLECTOR

INPATIENT/ORDERING PHYSICIAN/PROVIDER: FIRST NAME LAST NAME

DATE SPECIMEN COLLECTED: TIME IF COLLECTED AT <12 HRS OF AGE, REASON: TO BE TRANSFUSED OTHER (Specify):

TYPE OF SPECIMEN: HEELSTICK OTHER (Specify):

RBC TRANSFUSION BEFORE COLLECTION: NO YES - IF YES, date/time last transfusion completed:

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):

INITIAL SPECIMEN REPEAT OF INADEQUATE OR EARLY (<12 HRS) INITIAL SPECIMEN OTHER REPEAT (Specify in comments)

COMMENTS:

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)

PHYSICIAN FIRST NAME LAST NAME PHYSICIAN PHONE

STREET ADDRESS SUITE CITY STATE ZIP

PLEASE SEE PRIVACY NOTIFICATION WITHIN

To register, request form NBS-TRF from the Genetic Disease Screening Program, Newborn Screening Branch (510) 412-1942 (CDPH) - 10/07

903™ LOT 7102718 REF 10534790 EXPIRATION DATE W171 Rev AC 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

NBS FORM # 32 093 835 64

CDPH USE ONLY

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING
PLACE ACCESSION BARCODE HERE

903™ LOT 7102718 REF 10534790 EXPIRATION DATE W171 Rev AC 03/31/2021

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

