

Read carefully: New Instructions

If the test is refused make sure the parent or legal guardians sign the TRF. Add the date of refusal.

DO NOT DETACH

INSTRUCTIONS FOR COLLECTING ADEQUATE BLOOD SPOT SPECIMEN
Puncture site is indicated by shaded area on heel. Do not collect from side or back of foot.

***NO COURIER PLASTIC BAGS**

RIGHT ACCEPTABLE
Circle filled and evenly saturated

WRONG UNACCEPTABLE
Layering
Insufficient multiple applications
Serum rings present

NOTE:
- Do not use capillary tubes for collection of blood spot specimen.
- Do not collect blood from antecubital space or dorsal hand vein.
- Do not handle blood collection area of specimen collection card prior to, during, or following sampling.

- Position infant's foot to increase blood flow. Warming of the heel is optional.
- Clean skin with alcohol and either air-dry or wipe dry with sterile gauze.
- Puncture heel with sterile disposable lancet, using a firm, quick puncture. If using an automated lancet device, place it firmly against the heel prior to device activation.
- Allow a large drop of blood to accumulate and wipe away with sterile gauze.
- Allow a second large drop of blood to accumulate. Apply gentle pressure to heel and ease intermittently so blood flows freely.
- Apply the blood drop to one side of the specimen collection paper until the circle is filled COMPLETELY when viewed from both sides. Do not press collection paper against puncture site. Allow blood to fill circle by natural flow. Do not apply blood to both sides of the paper. Fill the first circle completely before moving on to the next circle. Repeat procedure for each circle.
- Allow blood spots to air-dry at room temperature for at least three hours. Keep away from direct light (sun or lamp) and heat.
- Do not dose specimen collection form while blood spots are still wet. Do not allow wet specimens to come in contact with each other.
- DO NOT PUT SPECIMEN IN PLASTIC BAG AT ANY TIME.

ADDITIONAL INSTRUCTIONS ARE CONTAINED IN "BLOOD COLLECTION ON FILTER PAPER FOR NEWBORN SCREENING PROGRAMS", 6th EDITION (CLSI NBS01-A6: Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard - Sixth Edition)

PRINT ONLY, USE ALL CAPITAL LETTERS, USE BLACK OR BLUE INK ONLY.

New Format! Fill the six spots completely. Note the new spot position.

The filter paper should not come apart, however if they do separate, put name, date and medical record or hospital code number in the white space above and below the NBS Form Number.

If you have any questions please call your local NBS Area Service Center.

DO NOT WRITE IN THIS AREA
DO NOT HANDLE FILTER PAPER
THIS AREA MAY BE USED TO ADHERE A STICKER CONTAINING THE INFANT'S FACILITY INFORMATION

**CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING**

INSTRUCTIONS FOR COMPLETION OF FORM
PLEASE PRINT AND USE BLUE OR BLACK BALL POINT PEN

- NEWBORN'S NAME:** Name as entered on birth certificate, last name first. If multiple birth, indicate A, B, C, etc.
- NEWBORN'S BIRTH DATE (AND TIME):** As entered on the birth certificate. All time is to be entered by the 24 hour clock, e.g., 8:30 a.m. is 0830; 9:01 p.m. is 2101.
- BIRTH WEIGHT:** In grams, as entered on birth certificate.
- GESTATIONAL AGE:** Enter gestational age at time of birth in weeks.
- MEDICAL RECORD NUMBER:** Enter number used in medical records department of facility collecting specimen.
- HOSPITAL ORDER NUMBER:** Use for HL7 messaging only.
- ALL FEEDINGS SINCE BIRTH:** Include all feeding from birth to collection. Human milk includes breastfeeding, mother's own expressed milk and banked human milk. If newborn has had neither human milk, nor formula then choose Nothing by mouth (NPO).
- NURSERY TYPE:** Check NICU/PICU, Regular Nursery (which includes Family Centered Care (FCC), Rooming In (RI), or Mother Baby Unit), Home Birth, or Outpatient.
- THIS BABY IS A WARD OF THE COURT:** Fill in the circle (•) if newborn is a ward of the court and provide contact information for legal guardian responsible for baby's care at time of collection.
- RACE/ETHNICITY:** As entered for both parents on birth certificate. These data are required by Government Code 8310.5. Check ALL that apply.
- MOTHER'S INFORMATION:** Name as entered on birth certificate, last name first. Please also include mother's maiden name and last 4 digits of social security number. If mother does not have a social security number, enter 9999.
- PRIMARY LANGUAGE:** Please indicate primary language spoken by mother; this helps determine if an interpreter is needed.
- FACILITY DRAWING SPECIMEN:** Name and code number must be entered to ensure correct reporting of results.
- INITIALS OF COLLECTOR:** Enter initials of person drawing the specimen.
- INPATIENT/ORDERING PHYSICIAN:** Name of physician ordering the test or providing care in the hospital.
- DATE SPECIMEN COLLECTED:** Date and hour of specimen collection. This refers to the time the specimen is collected from the newborn.
- IF COLLECTED AT <12 HRS OF AGE, REASON?:** If this specimen is being collected prior to the newborn being 12 hours of age, indicate why.
- TYPE OF SPECIMEN:** Please check only one box. If "OTHER" type of specimen is checked, please specify the type of specimen.
- RBC TRANSFUSION BEFORE COLLECTION:** Please indicate whether the newborn was transfused with RED BLOOD CELLS and the date and time the last transfusion ended prior to specimen collection. DO NOT list intravenous transfusions. DO NOT list transfusions that occurred after the specimen was collected.
- SPECIMEN NOT OBTAINED:** Check reason if specimen is not obtained. If refused, make sure a parent/guardian signs and dates the refusal section. If baby expired, please provide date and reason in comments. If urgent transfer, specify receiving hospital in comments. For any other reason, check box and specify in comments.
- NEWBORN'S PHYSICIAN'S NPI NUMBER OR LICENSE NUMBER:** Enter the physician's national provider identification number or California license number.
- NEWBORN'S OUTPATIENT PHYSICIAN INFORMATION:** Confirm with mother the name and contact information for the physician who will be responsible for newborn's care after discharge.
- DISTRIBUTION:** Original MUST remain attached to specimen. Facility drawing the specimen should retain and file the yellow copy in the newborn's chart. The pink copy should be given to the newborn's parent(s) with instructions to give to the newborn's outpatient physician at first visit.

PLEASE SEE PRIVACY NOTIFICATION WITHIN

CDPH-4408 NBS FORM # 32 000 001



www.cdph.ca.gov/programs/NBS

Important Changes to Completing the NBS 32 Million Series Form

Fill out a Test Request Form (TRF) for every infant. Completed TRFs must be sent to the NAPS Lab whether a specimen is collected, not obtained or refused.

Changes And New Fields

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

Series Indicator

32 000 001 65

BABY'S INFORMATION PLEASE PRINT USING ALL CAPITAL LETTERS

BABY'S LAST NAME **DATE OF BIRTH** **BIRTH HOUR**

FIRST NAME **GMS** **WEIGHT** **SEX** **BIRTH ORDER** **IF A.M.** **MULTIPLE** **C.M.**

STREET ADDRESS **APT**

CITY **ZIP**

MEDICAL RECORD # **HOSPITAL ORDER #**

NEWBORN ON TWIN/PERIL OR ABANDONED AT TIME OF COLLECTION? **ALL FEEDINGS SINCE BIRTH (Check One)** **NURSERY TYPE:** **THIS BABY IS A WARD OF THE COURT?**

RACE/ETHNICITY: FILL ALL THAT APPLY

MOTHER'S INFORMATION PLEASE PRINT USING ALL CAPITAL LETTERS

MOTHER'S LAST NAME **MOTHER'S BIRTH DATE**

FIRST NAME **MOTHER'S SSN**

MAIDEN NAME **MOTHER'S SSN LAST 4 DIGITS**

MOM - PHONE **ALTERNATE PHONE**

PRIMARY LANGUAGE (fill only ONE circle): **OTHER (Specify):**

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

INPATIENT/ORDERING PHYSICIAN PROVIDER: **FIRST NAME** **LAST NAME**

DATE SPECIMEN COLLECTED: **IF COLLECTED AT <12 HRS OF AGE, REASON:** **RBC TRANSFUSION BEFORE COLLECTION:**

TYPE OF SPECIMEN: **REASON FOR TEST: (fill only ONE circle):**

SPECIMEN NOT OBTAINED (if not collected specify why): **REASON FOR TEST: (fill only ONE circle):**

COMMENTS:

IF 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):

NPI # OR LIC # **PHYSICIAN PHONE**

PHYSICIAN LAST NAME

FIRST NAME

STREET ADDRESS **SUITE**

CITY **ZIP**

PLEASE SEE PRIVACY NOTIFICATION WITHIN

To order, request form NBS-TRF from the Genetic Disease Screening Program, Newborn Screening Branch (P.O. Box 41546) (CDPH - 4408)

903 CT 7102718 W171 10534790 Rev AC 02/31/2021

- Stamp here or place sticker with the NBS provider code.
- All information related to the baby has been moved together.
- Information related to the parent/legal guardian has been moved together.
- If infant is less than 1000 grams, enter a leading zero in the first box (example: 0750 grams). complete the four digit number
- TPN Since Birth:
TPN has been added back. Select TPN if given at anytime since birth.
- If Collection occurs after first 30 days please enter current weight.

IMPORTANT!

DO NOT USE AN EXPIRED FORM. Check the expiration date listed next to the hourglass icon.

