

SPECIMEN:
 1ST 2ND OTHER
 DIET TRANS. F/U * 0 0 0 5 5 9 3 2 5 6 * DE

DO NOT WRITE IN THIS SPACE

Baby's Last Name, First Name (PRINT) Sex Birth Date Birth Time
 : : : 24 hr
 : : : am
 : : : pm

Birth Weight/Grams Multiple Birth Order A-H Rec. # Antibiotics at time of draw Gestation Weeks

Specimen Date Time of Day Specimen Taken By Unit Location

FEEDING, LAST 24 HOURS
 Breast Soy Lactose NPO Other
 Transfusion, RBC Hyperalimentation (TPN)
 Latest Date Start Date End Date

Submitter/Hospital/Code Physician/Code
 Race/Ethnicity—Check all that apply:
 White Black/Afr. Amer. Amer.Ind./Alaskan Nat. Asian Indian Asian/Pac.Islander
 Chinese Filipino Japanese Korean Vietnam Nat. Hawaiian
 Guamanian or Chamorro Samoan Hispanic Other

MOTHER'S INFORMATION
 Last name, First Name OR Adoption Agency
 Address – Number, Street, Apt. #
 City State Zip
 Phone # Mother's Age
 Additional Contact Phone #, Name

HEP B IMMUNIZATION: Hep B1 HBIG Date / /

HEARING
 OAE L Ear Pass Fail R Ear Pass Fail Date / /
 ABR L Ear Pass Fail R Ear Pass Fail Date / /
 If not performed, reason: Technical Problem No Equipment
 Caregiver Refused Baby Discharged Other
 Follow-up appt. date: ____/____/____
 Location: _____

**NEW FORM
 EXPIRES APRIL 30, 2012**

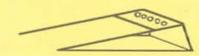
PLEASE PRINT LEGIBLY

W083 10534603 Rev.2
 REF 6836809
 LOT 2012-04



DO NOT REMOVE THIS OVERLAY

Allow blood specimens to air dry for at least 3 hours using the overlay for support. Close overlay when dry. See back for detailed instructions.



2012-04

SPECIMEN:
 1ST 2ND OTHER * 0 0 0 5 5 8 2 8 2 4 * DE

DO NOT WRITE IN THIS SPACE

Baby's Last Name, First Name (PRINT) Sex Birth Date Time of Day
 : : : 24 hr
 : : : am
 : : : pm

Birth Weight grams If multiple birth Indicate Birth order A-H Infant's age at time of collection Gest. Age at Birth weeks
 : : : < 24 hours : > 24 hours

Med. Rec. # Specimen Date Time of Day Specimen Taken By Unit / Dept.

FEEDING, LAST 24 HOURS
 Breast Soy Lactose NPO Other
 Transfusion, RBC Hyperalimentation (TPN)
 Latest Date Start Date End Date

Submitter/Hospital/Code Physician/Code
 Race/Ethnicity—Check all that apply:
 White Black/Afr. Amer. Amer.Ind./Alaskan Nat. Asian Indian Asian/Pac.Islander
 Chinese Filipino Japanese Korean Vietnam Nat. Hawaiian
 Guamanian or Chamorro Samoan Hispanic Other

MOTHER'S INFORMATION
 Last name, First Name OR Adoption Agency
 Address – Number, Street, Apt. #
 City State Zip
 Phone Number Mother's Age

HEP B IMMUNIZATION: Hep B1 HBIG Date / /
 Screening Method: ABR OAE Date / /
 LEFT EAR: Pass Fail RIGHT EAR: Pass Fail
 If not screened, reason: Technical Problem No Equipment
 Caregiver Refused Baby Discharged Other

HEARING
 Hearing Risk Factors – Check all that apply:
 Blood relative of infant has a permanent hearing loss that began at birth or early childhood
 Infant is suspected of having a congenital infection (herpes, CMV, syphilis, toxoplasmosis)
 Infant has craniofacial anomalies-pinna/ear canal abnormality, cleft palate, hydrocephalus
 Infant was placed in Level II or III (SCN) nursery for more than 48 hours
 Infant has serum bilirubin level ≥ 15 mg/dL

**OLD FORM
 EXPIRES JULY 31, 2009**

PLEASE PRINT LEGIBLY

W071 10534603 Rev.1
 REF 6272907
 LOT 2009-07



DO NOT REMOVE THIS OVERLAY

Allow blood specimens to air dry for at least 3 hours using the overlay for support. Close overlay when dry. See back for detailed instructions.



FILTER PAPER EXPIRATION ALERT
EXPIRATION DATE 07/31/09



**THE EXPIRATION DATE IS LOCATED ON THE
SCREENING STUB TOP LEFT SIDE**

Please check your newborn screening specimen forms for filter paper expiration date on each form *before* specimen collection.

The filter paper (card) for newborn screening blood collection has a shelf life of three years. If a specimen is collected on expired filter paper, the specimen will be unsatisfactory for testing and a repeat collection will be required. **Specimens collected on expired forms after the expiration date July 31, 2009 will be rejected for testing.**

**Please return expired forms to:
Delaware Newborn Screening Program
417 Federal Street
Dover, DE 19901**

To Request Forms Contact the Newborn Screening Lab at:

Email: labsupplies@state.de.us

Fax: (302) 653-1928

For Questions About Testing Contact Newborn Screening Lab at:

Phone: (302) 223-1520

8:00 am – 4:30 pm

To Contact Delaware Newborn Screening Program Office

1-800-262-3030 or (302) 744-4544