

Instructions for Completing NBS Collection Device

PURPOSE

To be used when requesting the Division of Consolidated Laboratories to perform dried blood spot testing for the mandated Newborn Screening Program in Virginia.

FORM

Four-part NCR paper with PE226 filter paper (or equivalent) attached for sampling. If writing on the collection device, adequate pressure must be used with a ballpoint pen to make all copies legible. Please print clearly within each block. If using electronic messaging, please affix a completed label to the center of each of the copies.

The physician, midwife, or nurse who delivered the baby at birth should initiate these forms. They may also be completed by the nursery, clinic or private office that attends to the baby after birth.

Please see the attached examples of properly filled out collection devices below.

NOTE: The top copy (parent copy) must be removed after the infant's name is entered, and given to the parent(s) or guardian of the newborn.

EXPLANATION FOR TERMS

BABY'S NAME - Give the last name or family name of the baby in the first section. Follow this with the first name of the baby, if it has been named. If the baby has not been named, use "BG" or "BB".

MEDICAL RECORD NUMBER - Give the baby's medical record ID #, which the hospital assigned to the baby at birth.

BIRTH DATE– Give the month, day and year baby was born (i.e. 03-20-16).

BIRTH TIME (MILITARY) - Give time of day the baby was born, using military time (i.e. 4:20p.m. is equivalent to 1620 hours).

SEX– Check the box for the sex of the baby as male, female, or ambiguous.

BIRTH WEIGHT- Give the weight of the baby at time of birth in grams (NOT pounds and ounces).

CURRENT WEIGHT- Give the weight of the baby at the time of sample collection, in grams (NOT pounds and ounces)

ETHNICITY- Use the following legend to check the appropriate ethnicity:

- 1). Hispanic
- 2). Non-Hispanic

3). Unknown

RACE - Use the following legend to check the appropriate box for the race of the baby:

- 1) BLK- Black
- 2) WHT- Caucasian
- 3) ASIAN- Vietnamese, Thai, Pakistani, Indian, Korean, Chinese, Japanese or Filipino
- 5) AMER. INDIAN- American Indian, Alaskan Native
- 6) MIXED/OTHER– Biracial, Mixed, Unknown

FEEDING TYPE - Check the appropriate box to indicate how the baby is being fed:

- 1) Breast
- 2) Cow's Formula
- 3) TPN
- 4) Soy Formula
- 5) Other (enter how the child is being fed)

MULTIBIRTH- If the baby is a multiple (a twin, triplet, etc), check the YES box and give the BIRTH ORDER (#).

DATE OF COLLECTION- Give the month, day and year of specimen collection (i.e. 04-03-16).

TIME OF COLLECTION (MILITARY)- Give the time of day the specimen is collected, using military time (i.e. 2:15 p.m. is equivalent to 1415 hours).

GESTATIONAL AGE AT BIRTH- Give the gestational age of the infant at birth (e.g. 35 weeks).

TRANSFUSED– If the infant has NOT had a transfusion, check the “N” box. If the child has been transfused with any blood products, check the “Y” box for transfusion. Then, enter the date in the appropriate box to indicate when the infant had the transfusion and check the type of products the baby received.

BABY'S ADDRESS- Enter the address at which the child resides.

BABY'S TELEPHONE NUMBER- Enter the phone number at which the baby's parent(s) or responsible guardian can be reached.

MOTHER'S NAME- Give the last name, first name, and maiden name of the mother.

(MOTHER'S) BIRTH DATE- Give the month, day and year the mother was born (i.e. 02-06-90).

SSN (LAST 4 DIG.)- Give the last four digits of the mother's social security number.

ADOPTION/FOSTER CARE– Check “No” if the baby is NOT being adopted or placed in foster care. Check “Yes”, if the baby is being adopted or placed in foster care.

PRACTICE/PROVIDER IDENTIFIER- Enter the code as assigned by DCLS for the physician who is treating the baby (post-discharge or in NICU) and can be reached to obtain follow-up information.

(Health Care Provider) TELEPHONE NUMBER- Enter the phone number of the physician who is treating the baby (post-discharge or in NICU) and that can be reached to obtain follow-up information.

BABY’S HEALTH CARE PROVIDER and HEALTH CARE PROVIDER’S ADDRESS- Enter the name and address of the health care provider who is treating the baby and that can be reached to obtain follow-up information.

BIRTH HOSPITAL CODE or BIRTH OUT OF HOSPITAL CODE- Enter the unique code assigned by DCLS for the hospital or birth center where the baby was born. Check “birth out of hospital” if the birth occurred at home or anywhere other than a hospital or birth center. If you do not know the hospital code number, please email to DCLS-submitterchange@dgs.virginia.gov to obtain the correct code.

BIRTH HOSPITAL TELEPHONE NUMBER, BIRTH HOSPITAL NAME, and ADDRESS- Enter the Hospital’s name, telephone number, and complete address of where the baby was born. If infant was not born in a hospital, please enter this information appropriately (i.e. phone number, name of the midwife/facility and address).

SUBMITTER SAME AS– Check appropriate box as the Place of Birth or Provider. If the submitter is different from the provider or place of birth, do not check either box.

SUBMITTER CODE, TELEPHONE NUMBER, NAME, and ADDRESS- If different from the place of birth, enter the submitter’s code, name, telephone number, and complete address. This name should match the submitter code description on file with DCLS and to whom the laboratory results should be mailed. If you do not know this number, please email to DCLS-submitterchange@dgs.virginia.gov to obtain the correct code.

SPECIMEN COLLECTED BY (PRINT NAME) - Print clearly the last and first name of the person who collected the sample.

FORM COMPLETED BY (PRINT NAME - LAST, FIRST) - Print clearly the last and first name of the person that completed the sample form.

PROCEDURE FOR SUBMITTING SAMPLES

Refer to the reverse side of "DCLS Newborn Screening Specimen Collection" form for collection instructions. It is extremely important that samples be air dried (for 3 hours) and sent to the laboratory within 24 hours from time of sample collection. Specimens must NOT be submitted in plastic bags, as this will affect specimen quality.

Samples should be mailed in the pre-addressed envelopes provided in your kit(s).

Please do not submit more than five (5) samples per envelope to the laboratory. This will help avoid the possibility of sample to sample contamination as well as facilitate automated sorting by the U.S. Postal Service, if being mailed.

REPORTING OF RESULTS

On a daily basis, normal results will be sent via courier, US Mail or electronic messaging, in batches to submitters from the laboratory. Requests for repeat samples to verify results or for unsatisfactory samples will also be sent via US Mail. Additionally, repeat collection devices are sent with the repeat requests to the provider listed on the collection device. The Virginia Department of Health Nurse Follow-Up Team will report any results that require immediate attention via telephone, followed by a written report.

The physician, hospital, facility, midwife or clinic that is indicated as the "Submitter" and the "Baby's Health Care Provider" will receive the laboratory results report. Any additional copies can be obtained through the Newborn Screening Dried Blood Spot (NBSDBS) web portal at <https://dclsconnect.dgs.virginia.gov> or can be requested by telephone at (804) 648-4480 Ext. 171 or via fax (804) 225-2595 (for multiple requests). When requesting result information or a duplicate report, please provide baby's last name, birth date, and mother's full name.

EXAMPLES OF FILLED OUT COLLECTION DEVICES

<input type="checkbox"/> X X X X X X X X X		<input type="checkbox"/> XXXXXXXX		UNSAT FOR LAB CODE _____ USE DATE _____ INT. _____		DGS-DCLS COPY	
BABY'S NAME: LAST Goldstandard FIRST BB		MEDICAL RECORD NUMBER XYZ852AB1		BIRTH DATE 02-29-12		BIRTH TIME (MILITARY) 0101015	
BIRTH WEIGHT 31312 GRAMS		CURRENT WEIGHT 3299 GRAMS		ETHNICITY 1() HISPANIC 2(✓) NON-HISPANIC 3() UNKNOWN		RACE 1() BLK. 4() AMER. INDIAN 2() WHT. 5(✓) MIXED/OTHER 3() ASIAN	
MULTIBIRTH () YES		DATE OF COLLECTION 03-02-12		TIME OF COLLECTION (MILITARY) 01143		GESTATIONAL AGE AT BIRTH IN WEEKS 41	
BIRTH ORDER (#) _____		TRANSFUSED (✓) () Y		DATE: _____		1() RBCs 2() PLASMA 3() PLATELETS	
BABY'S ADDRESS 7785 Heelstick Terrace		CITY Richmond STATE VA ZIP CODE 23219		BABY'S TELEPHONE NUMBER 540-999-4433			
MOTHER'S NAME: LAST Goldstandard FIRST Sophia MAIDEN Powder		BIRTH DATE 07-23-75		SSN (LAST 4 DIG.) 1111		ADOPTION / FOSTER CARE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PRACTICE/PROVIDER IDENTIFIER D321654		TELEPHONE NUMBER 804-000-5555		BIRTH HOSPITAL CODE <input type="checkbox"/> Birth out of Hospital 099561		TELEPHONE NUMBER 804-123-4567	
BABY'S HEALTH CARE PROVIDER Bassinet to Diploma Pediatrics		BIRTH HOSPITAL NAME Richmond's Choice Hospital		SUBMITTER SAME AS: (✓) PLACE of BIRTH () PROVIDER			
HEALTH CARE PROVIDER'S ADDRESS 987654 Cradle Lane, Ste A		BIRTH HOSPITAL ADDRESS 6547 Delivery Way		SUBMITTER NAME _____			
CITY Midlothian STATE VA ZIP CODE 23511		CITY Richmond STATE VA ZIP CODE 23219		SUBMITTER'S ADDRESS _____			
Commonwealth of Virginia Department of General Services Newborn Screening Laboratory 800 N. 5th St. Richmond, VA 23219 Telephone: (804) 378-7730 Doc. # 8615(Rev.2)		SPECIMEN COLLECTED BY (PRINT NAME) Blanket, Zena LAST, FIRST		FORM COMPLETED BY (PRINT NAME) Rattle, Carolyn LAST, FIRST		Use by XXXX-XX	

Figure 1. Hospital Birth

<input type="checkbox"/> X X X X X X X X X		<input type="checkbox"/> XXXXXXXX		FOR UNSAT LAB CODE _____ USE DATE /INT. _____		DGS- DCLS COPY	
BABY'S NAME: LAST Goldstandard		FIRST BG	MEDICAL RECORD NUMBER XYZ852AB1	BIRTH DATE 02-29-12	BIRTH TIME (MILITARY) 0101015	SEX <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/> AMBIGUOUS	
BIRTH WEIGHT 31312 GRAMS	CURRENT WEIGHT 31299 GRAMS	ETHNICITY 1() HISPANIC 2(<input checked="" type="checkbox"/>) NON-HISPANIC 3() UNKNOWN	RACE 1() BLK. 4() AMER. INDIAN 2() WHT. 5(<input checked="" type="checkbox"/>) MIXED/OTHER 3() ASIAN	FEEDING TYPE 1(<input checked="" type="checkbox"/>) BREAST 4() SOY FORMULA 2() COW'S FORMULA 5() OTHER 3() TPN			
MULTIBIRTH () YES	DATE OF COLLECTION 03-02-12	TIME OF COLLECTION (MILITARY) 01142	GESTATIONAL AGE AT BIRTH IN WEEKS 40	TRANSFUSED (<input checked="" type="checkbox"/> N () Y)	DATE: _____	1(<input type="checkbox"/>) RBCs 2(<input type="checkbox"/>) PLASMA 3(<input type="checkbox"/>) PLATELETS	
BABY'S ADDRESS 7785 Heelstick Terrace		CITY Richmond	STATE VA	ZIP CODE 23219	BABY'S TELEPHONE NUMBER 540-999-4433		
MOTHER'S NAME: LAST Goldstandard		FIRST Sophia	MAIDEN Powder	BIRTH DATE 07-23-75	SSN (LAST 4 DIG.) 1111	ADOPTION / FOSTER CARE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PRACTICE/PROVIDER IDENTIFIER D321654	TELEPHONE NUMBER 804-000-5555	BIRTH HOSPITAL CODE <input checked="" type="checkbox"/> Birth out of Hospital 9999561	TELEPHONE NUMBER 804-123-4567	SUBMITTER SAME AS: (<input checked="" type="checkbox"/>) PLACE of BIRTH () PROVIDER			
BABY'S HEALTH CARE PROVIDER Bassinet to Diploma Pediatrics		BIRTH HOSPITAL NAME Embracing Arms Midwifery		SUBMITTER NAME			
HEALTH CARE PROVIDER'S ADDRESS 987654 Cradle Lane, Ste A		BIRTH HOSPITAL ADDRESS 12345 Birthday Lane		SUBMITTER'S ADDRESS			
CITY Midlothian	STATE VA	ZIP CODE 23511	CITY Richmond	STATE VA	ZIP CODE 23219	CITY _____ STATE _____ ZIP CODE _____	
Commonwealth of Virginia Department of General Services Newborn Screening Laboratory 600 N. 5th St. Richmond, VA 23219 Telephone: (866) 378-7730 Doc. # 8615(Rev.2)		SPECIMEN COLLECTED BY (PRINT NAME) Blanket, Zena LAST, FIRST		FORM COMPLETED BY (PRINT NAME) Rattle, Carolyn LAST, FIRST		Use by XXXX-XX	

Figure 2. Birth out of Hospital

<input type="checkbox"/> X X X X X X X X X		<input type="checkbox"/> XXXXXXXX		FOR UNSAT LAB CODE _____ USE DATE /INT. _____		DGS- DCLS COPY	
BABY'S NAME: LAST Goldstandard		FIRST BB "2"	MEDICAL RECORD NUMBER XYZ852AB1	BIRTH DATE 02-29-12	BIRTH TIME (MILITARY) 0101015	SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> AMBIGUOUS	
BIRTH WEIGHT 1892 GRAMS	CURRENT WEIGHT 1880 GRAMS	ETHNICITY 1() HISPANIC 2(<input checked="" type="checkbox"/>) NON-HISPANIC 3() UNKNOWN	RACE 1() BLK. 4() AMER. INDIAN 2() WHT. 5(<input checked="" type="checkbox"/>) MIXED/OTHER 3() ASIAN	FEEDING TYPE 1() BREAST 4() SOY FORMULA 2() COW'S FORMULA 5() OTHER 3(<input checked="" type="checkbox"/>) TPN			
MULTIBIRTH (<input checked="" type="checkbox"/>) YES	DATE OF COLLECTION 03-02-12	TIME OF COLLECTION (MILITARY) 01142	GESTATIONAL AGE AT BIRTH IN WEEKS 33	TRANSFUSED () N (<input checked="" type="checkbox"/>) Y)	DATE: 030112	1(<input checked="" type="checkbox"/>) RBCs 2(<input type="checkbox"/>) PLASMA 3(<input type="checkbox"/>) PLATELETS	
BABY'S ADDRESS 7785 Heelstick Terrace		CITY Richmond	STATE VA	ZIP CODE 23219	BABY'S TELEPHONE NUMBER 540-999-4433		
MOTHER'S NAME: LAST Goldstandard		FIRST Sophia	MAIDEN Powder	BIRTH DATE 07-23-75	SSN (LAST 4 DIG.) 1111	ADOPTION / FOSTER CARE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PRACTICE/PROVIDER IDENTIFIER D321654	TELEPHONE NUMBER 804-000-5555	BIRTH HOSPITAL CODE <input type="checkbox"/> Birth out of Hospital 009442280	TELEPHONE NUMBER 804-123-4567	SUBMITTER SAME AS: (<input checked="" type="checkbox"/>) PLACE of BIRTH () PROVIDER			
BABY'S HEALTH CARE PROVIDER Bassinet to Diploma Pediatrics		BIRTH HOSPITAL NAME Richmond's Choice Hospital NICU		SUBMITTER NAME			
HEALTH CARE PROVIDER'S ADDRESS 987654 Cradle Lane, Ste A		BIRTH HOSPITAL ADDRESS 6547 Delivery Way		SUBMITTER'S ADDRESS			
CITY Midlothian	STATE VA	ZIP CODE 23511	CITY Richmond	STATE VA	ZIP CODE 23219	CITY _____ STATE _____ ZIP CODE _____	
Commonwealth of Virginia Department of General Services Newborn Screening Laboratory 600 N. 5th St. Richmond, VA 23219 Telephone: (866) 378-7730 Doc. # 8615(Rev.2)		SPECIMEN COLLECTED BY (PRINT NAME) Blanket, Zena LAST, FIRST		FORM COMPLETED BY (PRINT NAME) Rattle, Carolyn LAST, FIRST		Use by XXXX-XX	

Figure 3. Transfused