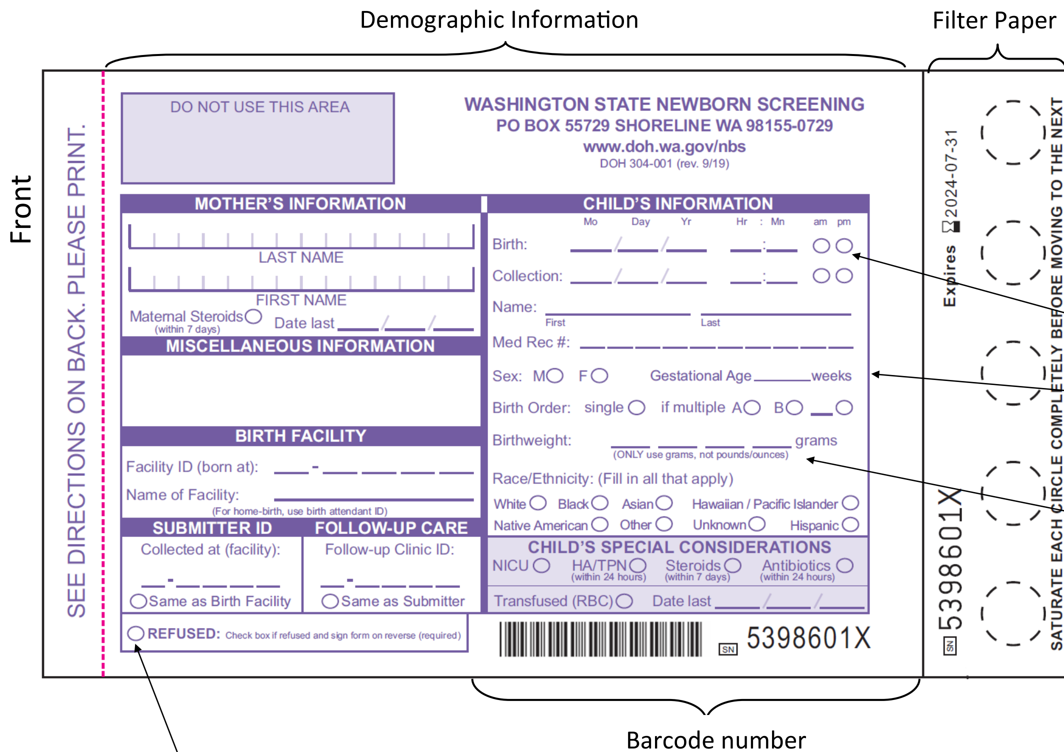
Newborn Screening Collection Card Instructions

Washington State Department of Health

DOH 951-125 Sep 2019

Collection Cards — Fall 2019



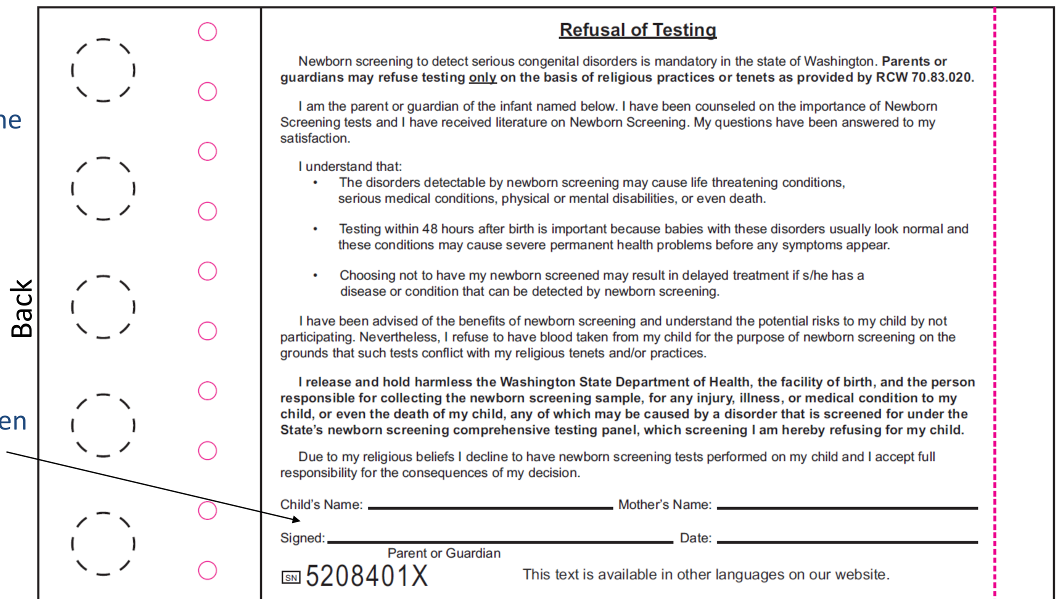
Please use your supply of existing older cards prior to use of the new cards.

Key features of new cards:

- Now “bubbles” instead of “boxes. Please fill in bubbles completely
- New Field— Gestational Age! Please write in full weeks. Do not use days or decimals.
- Birth weight in grams only now Do not use kilogram, pounds/ounces
- Cards are in royal purple ink

If parents refuse newborn screening for religious reasons:

- Have parents read the Refusal of Testing statement on the back of the screening card. Text is available on our website in other languages for reference only.
- Complete all demographic information on the front of the card AND check the box indicating “Refused”
- Parents must sign and date specimen card to indicate refusal of testing
- Mail refusal cards to the State Laboratory right away, just like a blood specimen



Refusal of Testing

Newborn screening to detect serious congenital disorders is mandatory in the state of Washington. **Parents or guardians may refuse testing only on the basis of religious practices or tenets as provided by RCW 70.83.020.**

I am the parent or guardian of the infant named below. I have been counseled on the importance of Newborn Screening tests and I have received literature on Newborn Screening. My questions have been answered to my satisfaction.

I understand that:

- The disorders detectable by newborn screening may cause life threatening conditions, serious medical conditions, physical or mental disabilities, or even death.
- Testing within 48 hours after birth is important because babies with these disorders usually look normal and these conditions may cause severe permanent health problems before any symptoms appear.
- Choosing not to have my newborn screened may result in delayed treatment if s/he has a disease or condition that can be detected by newborn screening.

I have been advised of the benefits of newborn screening and understand the potential risks to my child by not participating. Nevertheless, I refuse to have blood taken from my child for the purpose of newborn screening on the grounds that such tests conflict with my religious tenets and/or practices.

I release and hold harmless the Washington State Department of Health, the facility of birth, and the person responsible for collecting the newborn screening sample, for any injury, illness, or medical condition to my child, or even the death of my child, any of which may be caused by a disorder that is screened for under the State's newborn screening comprehensive testing panel, which screening I am hereby refusing for my child.

Due to my religious beliefs I decline to have newborn screening tests performed on my child and I accept full responsibility for the consequences of my decision.

Child's Name: ______ Mother's Name: ______

Signed: ______ Date: ______

Parent or Guardian

SN 5208401X

This text is available in other languages on our website.

Please:

- Do not place stickers/tracking labels over any demographic information or the “DO NOT USE THIS AREA” section
- Do not separate the filter paper from the demographic information. The barcode number for the filter paper, demographic information section, and hearing card (if present) must match for each child
- Keep record of the unique barcode number in the child’s chart and/or on a tracking log of screening specimens submitted

For people with disabilities, this document is available upon request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY call 711).

Front Left

MOTHER'S INFORMATION

LAST NAME

FIRST NAME

Maternal Steroids ◯ (within 7 days) Date last ___/___/___

MISCELLANEOUS INFORMATION

BIRTH FACILITY

Facility ID (born at): ___-_______

Name of Facility: ________

(For home-birth, use birth attendant ID)

SUBMITTER ID | **FOLLOW-UP CARE**

Collected at (facility): ___-_______ ◯ Same as Birth Facility

Follow-up Clinic ID: ___-_______ ◯ Same as Submitter

◯ **REFUSED:** Check box if refused and sign form on reverse (required)

Complete list of ID numbers available online: www.doh.wa.gov/NBS/IDNumberDirectories

Mother's Information

- Write mother's legal first and last name (Do not include middle names)
- Fill in bubble if the *mother* received steroids within the last 7 days
- Indicate the date when steroids were last administered to the mother

Miscellaneous Information

- Indicate anything relevant, such as: adoption, foster care, surrogacy, CPS, family history of NBS disorders, moving/transferring out of state

Birth Facility

- Write the ID# for the hospital or birth center where the infant was born
- The card's yellow flap has a list of all birth facility ID#s for your use
- If home birth, write the individual midwife ID# ("M#")

Submitter ID

- Write the ID# for the facility where the specimen was collected
- If home collection, write the individual midwife ID# ("M#")
- Or fill the bubble if same as birth facility
- Test results will be mailed to the submitter

Follow-Up Care

- Write the ID# of the facility where the child will receive outpatient care*
- If child will remain in-house, write the hospital's ID#
- Or fill the bubble if same as submitter
- This facility will be contacted when abnormal results require follow-up

***No longer use individual provider ID#s**

Refused

- Check box if parents refuse testing AND obtain signature on back of card

Front Right

CHILD'S INFORMATION

	Mo / Day / Yr	Hr : Mn	am pm
Birth:	___/___/___	___:___	◯ ◯
Collection:	___/___/___	___:___	◯ ◯

Name: ________ (First) ________ (Last)

Med Rec #: ___________

Sex: M◯ F◯ Gestational Age _____ weeks

Birth Order: single ◯ if multiple A◯ B◯ __◯

Birthweight: ___ ___ ___ ___ grams (ONLY use grams, not pounds/ounces)

Race/Ethnicity: (Fill in all that apply)

White ◯ Black ◯ Asian ◯ Hawaiian / Pacific Islander ◯ Native American ◯ Other ◯ Unknown ◯ Hispanic ◯

CHILD'S SPECIAL CONSIDERATIONS

NICU ◯ HA/TPN ◯ (within 24 hours) Steroids ◯ (within 7 days) Antibiotics ◯ (within 24 hours)

Transfused (RBC) ◯ Date last ___/___/___

Child's Information

- Write the date AND time the child was born
- Write the date AND time the specimen was collected
  - — Use 24-hour based time OR fill appropriate AM/PM bubbles
    - ♦ Tests are specific to the child's exact age (in hours) when the specimen was collected
- Write the child's legal name and Medical Record # (if known)
- Fill the bubble for the sex and birth order of the child
  - ♦ This ensures the correct child is being identified
- Write the weight of the child *at birth* in grams
  - — Do not use pounds/ounces, kilograms, or punctuation
- For Race/Ethnicity, fill all bubbles that apply (if known)

Child's Special Considerations

- Fill the NICU bubble if child is or will be in the Intensive Care Unit or Special Care Nursery
- Fill the HA/TPN bubble if the child received hyperalimentation/total parenteral nutrition, or IV supplementation including amino acids **in the last 24 hours**
- Fill the STERIODS bubble if the child received steroids **in the last 7 days**
- Fill the ANTIBIOTICS bubble if the child received antibiotics **in the last 24 hours**
- Fill the TRANSFUSED bubble if the child received red blood cell transfusion