

Supplemental Kit Sample-September, 2016

Changes include:

Food Source has been collapsed

Weights are in Grams only

Gestational age has been added

A box around *Transfused* has been added

Placement of *Medical Record* has been moved

| EXPIRATION 2019-04 IVD 250055001 AZ | Newborn Screening PRINT ALL INFORMATION LEGIBLY Accession Number: AZ250055001 SUPPLEMENTAL SCREENING FORM DO NOT WRITE IN THIS SPACE Date / Time Stamp | | | | | | | | | | | | | | | | | | |
|---|--|--|--|------|------------------|--------|----------------------------------|--|---|--|--|----------------------------------|--|---|---|----------------------------------|---|--|----------------------------|
| | <input type="checkbox"/> First Screen <input type="checkbox"/> Second Screen <input type="checkbox"/> Recall <small>(Indicate disorder to be tested)</small> | Submitter / Physician Information AZ250055001 <small>SN</small> | | | | | | | | | | | | | | | | | |
| | Baby's Name Last: _____ First: _____ Date of Birth: ____/____/____ Time of Birth: ____ a.m. / ____ p.m. Birth Weight: _____ Grams Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of Collection: ____/____/____ Time of Collection: ____ a.m. / ____ p.m. Current Weight: _____ Grams | Submitter Name/ID: _____ Submitter Address: _____ Physician's Name (Last, First): _____ Phone: (____) _____ Physician's Address: _____ City, State, Zip: _____ | | | | | | | | | | | | | | | | | |
| | Baby's AHCCCS # _____ Gestational Age _____ <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth (circle one) A B C D | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Race</th> <th style="width: 45%;">Medical Record #</th> <th style="width: 30%;">Status</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 1 White</td> <td rowspan="5" style="text-align: center; vertical-align: middle;"> Food Source <input type="checkbox"/> 1 Breast Only <input type="checkbox"/> 2 Milk <input type="checkbox"/> 3 Formula (Soy or Milk) <input type="checkbox"/> 4 TPN <input type="checkbox"/> 0 Not Fed </td> <td>Premature <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 2 African Amer.</td> <td>Meconium Ileus <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 3 Asian</td> <td>In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 4 Amer. Indian</td> <td>Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 5 Other</td> <td>Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td>Hispanic <input type="checkbox"/> Y <input type="checkbox"/> N</td> <td>Date Last Transfused _____</td> <td></td> </tr> </tbody> </table> | | Race | Medical Record # | Status | <input type="checkbox"/> 1 White | Food Source <input type="checkbox"/> 1 Breast Only <input type="checkbox"/> 2 Milk <input type="checkbox"/> 3 Formula (Soy or Milk) <input type="checkbox"/> 4 TPN <input type="checkbox"/> 0 Not Fed | Premature <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> 2 African Amer. | Meconium Ileus <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> 3 Asian | In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> 4 Amer. Indian | Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> 5 Other | Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N | Hispanic <input type="checkbox"/> Y <input type="checkbox"/> N | Date Last Transfused _____ |
| Race | Medical Record # | Status | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 1 White | Food Source <input type="checkbox"/> 1 Breast Only <input type="checkbox"/> 2 Milk <input type="checkbox"/> 3 Formula (Soy or Milk) <input type="checkbox"/> 4 TPN <input type="checkbox"/> 0 Not Fed | Premature <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 2 African Amer. | | Meconium Ileus <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 3 Asian | | In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 4 Amer. Indian | | Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> 5 Other | | Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N | | | | | | | | | | | | | | | | | |
| Hispanic <input type="checkbox"/> Y <input type="checkbox"/> N | Date Last Transfused _____ | | | | | | | | | | | | | | | | | | |
| Pulse Oximetry FINAL Screen Results <input type="radio"/> Pass (passed on attempt) 1 st ____; 2 nd ____; 3 rd ____ <input type="radio"/> Not screened: <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Parental Cardiac Diagnosis Reason (choose one) <input type="checkbox"/> Monitored NICU/SON <input type="checkbox"/> Other _____ | Mother's Information Mom's Name Last: _____ First: _____ Mom's Date of Birth: ____/____/____ Maiden Name: _____ Street Address: _____ City, State, Zip: _____ Phone: (____) _____ Other Person with Custody: _____ Mom's AHCCCS# _____ | | | | | | | | | | | | | | | | | | |

HAVE YOU:

- Discussed NBS rationale and procedure with the parents?
- Air-dried blood spots in a horizontal position with the flap folded back?
- Checked to see that the blood spots are completely dry and protective flap is in place before submitting specimen?

This flap is for the protection of the specimen and the specimen handlers

BIOHAZARD

Linked Kit Sample—September, 2016

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|---|--|--|
| EXPIRATION 2019-04 IVD 251110001 AZ | Newborn Screening PRINT ALL INFORMATION LEGIBLY Accession Number: DO NOT WRITE IN THIS SPACE 1st SPECIMEN Date / Time Stamp | Submitter / Physician Information AZ251110001 Submitter Name/ID: _____ Submitter Address: _____ Physician's Name (Last, First): _____ Phone: (____) _____ Physician's Address: _____ City, State, Zip: _____ |
| | Baby's Name Last: _____ First: _____ Date of Birth: ____/____/____ Time of Birth: ____ a.m. / ____ p.m. Birth Weight: _____ Grams Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of Collection: ____/____/____ Time of Collection: ____ a.m. / ____ p.m. Current Weight: _____ Grams Baby's AHCCCS # _____ Gestational Age: _____ <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth (circle one) A B C D _____ | Race: <input type="checkbox"/> 1 White <input type="checkbox"/> 2 African Amer. <input type="checkbox"/> 3 Asian <input type="checkbox"/> 4 Amer. Indian <input type="checkbox"/> 5 Other Medical Record #: _____ Food Source: <input type="checkbox"/> 1 Breast Only <input type="checkbox"/> 2 Milk <input type="checkbox"/> 3 Formula (Soy or Milk) <input type="checkbox"/> 4 TPN <input type="checkbox"/> 5 Not Fed Status: Premature <input type="checkbox"/> Y <input type="checkbox"/> N Meconium Pass <input type="checkbox"/> Y <input type="checkbox"/> N In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N Date Last Transfused: _____ Pulse Oximetry FINAL Screen Results: <input type="checkbox"/> Pass (passation attempt) 1 st ____; 2 nd ____; 3 rd ____ <input type="checkbox"/> Not screened Reason: _____ <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Perinatal Cardiac Defect <input type="checkbox"/> Fail (choose one) <input type="checkbox"/> Maternal/NCUSCN <input type="checkbox"/> Other _____ |
| EXPIRATION 2019-04 IVD 252110001 AZ | Newborn Screening PRINT ALL INFORMATION LEGIBLY Accession Number: DO NOT WRITE IN THIS SPACE 2nd SPECIMEN Date / Time Stamp | Submitter / Physician Information AZ252110001 Submitter Name/ID: _____ Submitter Address: _____ Physician's Name (Last, First): _____ Phone: (____) _____ Physician's Address: _____ City, State, Zip: _____ |
| | Baby's Name Last: _____ First: _____ Date of Birth: ____/____/____ Time of Birth: ____ a.m. / ____ p.m. Birth Weight: _____ Grams Sex: <input type="checkbox"/> M <input type="checkbox"/> F Date of Collection: ____/____/____ Time of Collection: ____ a.m. / ____ p.m. Current Weight: _____ Grams Baby's AHCCCS # _____ Gestational Age: _____ <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth (circle one) A B C D _____ | Race: <input type="checkbox"/> 1 White <input type="checkbox"/> 2 African Amer. <input type="checkbox"/> 3 Asian <input type="checkbox"/> 4 Amer. Indian <input type="checkbox"/> 5 Other Medical Record #: _____ Food Source: <input type="checkbox"/> 1 Breast Only <input type="checkbox"/> 2 Milk <input type="checkbox"/> 3 Formula (Soy or Milk) <input type="checkbox"/> 4 TPN <input type="checkbox"/> 5 Not Fed Status: Premature <input type="checkbox"/> Y <input type="checkbox"/> N Meconium Pass <input type="checkbox"/> Y <input type="checkbox"/> N In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N Date Last Transfused: _____ Pulse Oximetry FINAL Screen Results: <input type="checkbox"/> Pass (passation attempt) 1 st ____; 2 nd ____; 3 rd ____ <input type="checkbox"/> Not screened Reason: _____ <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Perinatal Cardiac Defect <input type="checkbox"/> Fail (choose one) <input type="checkbox"/> Maternal/NCUSCN <input type="checkbox"/> Other _____ |

- HAVE YOU:**
- Discussed NBS rationale and procedure with the parents?
 - Given linked second kit to mother?
 - Air-dried blood spots in a horizontal position with the flap folded back?
 - Checked to see that the blood spots are completely dry and protective flap is in place before submitting specimen?

This flap is for the protection of the specimen and the specimen handlers



- HAVE YOU:**
- Discussed NBS rationale and procedure with the parents?
 - Air-dried blood spots in a horizontal position with the flap folded back?
 - Checked to see that the blood spots are completely dry and protective flap is in place before submitting specimen?

This flap is for the protection of the specimen and the specimen handlers

