

# New Jersey Newborn Screening Specimen Collection Form Guidelines – PRINT CLEARLY

BABY'S LAST NAME (PRINT)		[SN] 16100001		DO NOT WRITE IN THIS AREA!	
Birth Date	Date of Sample	Type of Feeding <input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No	BABY'S MEDICAL RECORD NO.	
Birth Time <input type="checkbox"/> am <input type="checkbox"/> pm	Sample Time <input type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, A, B, C, etc.:	Meconium Ileus? <input type="checkbox"/> Yes <input type="checkbox"/> No	Remarks	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birthweight	Transfusion PRIOR to sample collection? If Yes, give date and time: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gestational Age	New Jersey Department of Health <b>INITIAL NEWBORN SCREENING REQUEST</b>	
MOTHER'S NAME (LAST, FIRST) (PRINT)		Mother's Age	Mother's Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian	4 <input type="checkbox"/> American Indian/Alaskan Native 5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 8 <input type="checkbox"/> Other	Collector's Initials / Date: Mother's Telephone No.
Address		Apt. #	HOSPITAL NAME AND ADDRESS		
City, State, Zip		BABY'S PHYSICIAN NAME AND ADDRESS			
Telephone No.		Telephone No.			
IEM-1 JAN 1 2019-02		SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician		H5782	

**Baby's Last Name:**  
Print LAST name only

**Multiple Births:**  
Check yes or no. If yes, indicate by writing A, B, C...etc.

**Type of Feeding:**  
Check type of feeding given\*  
  
Antibiotic: Check yes or no\*  
\*within 24 hours of sample collection\*

**Meconium Ileus:**  
Check yes or no

**Birth Date/Time and Sample Date/Time:**  
Print date mm/dd/yy.  
Print time in standard or military

**Remarks:**  
This is free space to clarify demographic information or add additional information

**Gender:**  
Check M or F. If genitals ambiguous, leave section blank and a note in "Remarks"

**Gestational Age:**  
Print age in weeks only.

**Always Check Expiration Date !**

**Baby's Birthweight:**  
Enter weight in **GRAMS** only

**Transfusion:**  
Check yes or no. If yes, indicate mm/dd AND time

**Mother, Hospital, and Physician Addresses:**  
Print all information within spaces provided. **NO** P.O. Box numbers. Add Apt. # if needed. If no phone #, enter secondary contact #

**Blue Bubbles- Critical for test Interpretation**  
**Yellow Bubbles – Critical for Identification**