

Supplemental Kit Sample-September, 2016

<p style="writing-mode: vertical-rl; transform: rotate(180deg);">EXPIRATION 2019-04</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">IVD</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">AZ SN 250055001</p>	<p style="text-align: center;">PRINT ALL INFORMATION LEGIBLY Accession Number:</p> <p style="text-align: center;">SUPPLEMENTAL SCREENING FORM DO NOT WRITE IN THIS SPACE</p> <p style="text-align: right;">Date / Time Stamp</p> <p> <input type="checkbox"/> First Screen <input type="checkbox"/> Second Screen <input type="checkbox"/> Recall <small>(Indicate disorder to be retested)</small> </p> <p> Submitter / Physician Information AZ250055001 </p> <p> Baby's Name Last: _____ First: _____ (SN) Date of Birth: ____/____/____ Time of Birth: ____ a.m. / ____ p.m. Birth Weight: ____ Grams Sex: <input type="checkbox"/> M Date of Collection: ____/____/____ Time of Collection: ____ a.m. / ____ p.m. Current Weight: ____ Grams <input type="checkbox"/> F </p> <p> Baby's AHCCCS # _____ Gestational Age _____ <input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth (circle one) A B C D </p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Race</th> <th style="width: 40%;">Medical Record #</th> <th style="width: 35%;">Status</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 1 White</td> <td>_____</td> <td>Premature <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 2 African Amer.</td> <td style="text-align: center;">Food Source</td> <td>Meconium Ileus <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 3 Asian</td> <td><input type="checkbox"/> 1 Breast Only</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><input type="checkbox"/> 2 Milk</td> <td>Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N</td> </tr> <tr> <td><input type="checkbox"/> 5 Other</td> <td><input type="checkbox"/> 3 Formula (Soy or Milk)</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><input type="checkbox"/> 4 TPN <input type="checkbox"/> 0 Not Fed</td> <td>Date Last Transfused: _____</td> </tr> </tbody> </table> <p> Pulse Oximetry FINAL Screen Results <input type="radio"/> Pass (passed on attempt) <input type="radio"/> Not screened: <input type="checkbox"/> Parental Refusal <input type="checkbox"/> Perinatal Cardiac Diagnosis 1st ____; 2nd ____; 3rd ____ Reason (choose one) <input type="checkbox"/> Monitored NICU/SCN <input type="checkbox"/> Other _____ <input type="radio"/> Fail </p> <p> Submitter Name/ID: _____ (SN) Submitter Address: _____ Physician's Name (Last, First): _____ Phone: (____) _____ Physician's Address: _____ City, State, Zip: _____ </p> <p style="text-align: center;">Mother's Information</p> <p> Mom's Name Last: _____ First: _____ Mom's Date of Birth: ____/____/____ Maiden Name: _____ Street Address: _____ City, State, Zip: _____ Phone: (____) _____ </p> <p> <input type="checkbox"/> Insurance papers included <input type="checkbox"/> Parent Refused Bloodspot Testing </p> <p> Other Person with Custody: _____ Mom's AHCCCS# _____ </p>	Race	Medical Record #	Status	<input type="checkbox"/> 1 White	_____	Premature <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 2 African Amer.	Food Source	Meconium Ileus <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 3 Asian	<input type="checkbox"/> 1 Breast Only	In NICU/Special Care Nursery <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 4 Amer. Indian	<input type="checkbox"/> 2 Milk	Known anomaly <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 5 Other	<input type="checkbox"/> 3 Formula (Soy or Milk)	Transfused before collection? <input type="checkbox"/> Y <input type="checkbox"/> N	Hispanic <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> 4 TPN <input type="checkbox"/> 0 Not Fed	Date Last Transfused: _____
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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



Linked Kit Sample—September, 2016

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"/> Partial Refusal <input type="checkbox"/> Perinatal Cardiac Disease <input type="checkbox"/> Fail (choose one) <input type="checkbox"/> Maternal INCLUSION <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"/> Partial Refusal <input type="checkbox"/> Perinatal Cardiac Disease <input type="checkbox"/> Fail (choose one) <input type="checkbox"/> Maternal INCLUSION <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?

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