Florida NBS
10534749 Rev.AE
Job # XXXXXXX-004
01-11-12

CUSTOMER	Whatman™
APPROVED ☐ NOT APPROVED ☐	
SIGNATURE	SIGNATURE
NAME:	REF: 10534749 REVISION: AE
DATE:	DATE:

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Perf does not print

Die Cut Window Size
3 3/8" x 1"

1) Do not touch sample area

Whatman 903™ LOT WXXX XXXXXXX
YYYY-MM
SN
0004697201

STATE LAB USE ONLY

2) Do not use if damaged or after expiry date.

SN
0004697201

STATE LAB USE ONLY

IF NOT SUBMITTING BLOOD CHECK ONE ○ REFUSED ○ INFORMATION ONLY | ○ E-VITALS COMPLETED ○ DECEASED ○ ADOPTION

INFANT'S INFORMATION

Infant's Last Name | Infant's First Name
Hospital of Birth | Infant's Medical Record Number
Date of Birth MM DD YY | Birth Time (Military Format) | GENDER ○ M ○ F ○ U | Birth Weight (gms) | Weight (gms) at Collection | A-H MULTIPLE BIRTH ORDER

SPECIMEN INFORMATION

○ FIRST ○ REPEAT ○ NPO ○ ORAL FEED ○ TPN/HYPERAL ○ ANTIBIOTIC

WEEKS OF GESTATION

NICU ○

First Feed Date (mm/dd/yy) | Time (Military Format)
Collection Date (mm/dd/yy) | Time (Military Format) | Collected By (Int.)
Transfused Date (RBC's) (mm/dd/yy) | Time (Military Format)

SELECT ALL THAT APPLY
○ WHITE ○ BLACK ○ AMERICAN INDIAN
○ HISPANIC ○ OTHER
○ ASIAN ○ PACIFIC ISLANDER

MOTHER'S INFORMATION

Mother's Last Name | Mother's First Name/Middle Initial
Mother's Address (include Apartment #) | City | State | Zip Code
Mother's Social Security Number | Mother's or Contact's Telephone Number | Alternate Telephone Number

PHYSICIAN'S INFORMATION

Last - First Name | Physician's Telephone No.

SUBMITTER INFORMATION

Name of Collection Facility | Laboratory ID#
Address | City | State | Zip Code

STATE OF FLORIDA-DEPT. OF HEALTH-BUREAU OF LABORATORIES 1217 PEARL STREET JACKSONVILLE, FL 32202 (904) 791-1644, (904) 791-1647
ALL SPECIMENS COLLECTED ON INFANTS <24 HRS. OF AGE / <24 HRS. ON PROTEIN MUST BE REPEATED AND SENT TO THE STATE LABORATORY. ALL FIELDS MUST BE FILLED OUT COMPLETELY TO AVOID DELAY.
Newborn Screening Specimen Collection Card, DH 677, MM-YY, Replaces ALL Previous Editions. Conforms to CLSI Standards.

INSURANCE INFORMATION

Insured's Name (Last, First, Middle (Initial)
Name of Insurance Co.
Insurance Group ID#
Insurance ID#
○ PRIVATE ○ MEDICAID | Mother's Medicaid Number
○ SELF-PAY
INSURED SSN – –

HEARING SCREENING
DARKEN CIRCLES THAT APPLY
M M D D Y Y
HEARING SCREENING DATE

RIGHT EAR ○ PASS ○ REFER ○ OAE ○ ABR
LEFT EAR ○ PASS ○ REFER ○ OAE ○ ABR

HEARING RISK STATUS: (DARKEN CIRCLES THAT APPLY)
○ FAMILY HISTORY ○ PPHN ○ ECMO ○ BIRTH WEIGHT <1500 GRAMS
○ EXCHANGE TRANSFUSION FOR HYPERBILIRUBINEMIA

REASON HEARING WAS NOT SCREENED PRIOR TO DISCHARGE: (DARKEN ALL CIRCLES THAT APPLY)
○ PARENT/GUARDIAN REFUSED ○ MISSED
○ FACILITY TRANSFER ○ BIRTH DEFECT
○ NOT YET SCREENED (NICU) ○ BABY EXPIRED

PRESS FIRMLY. YOU ARE MAKING MULTIPLE COPIES.
PLEASE FILL IN THIS CARD USING CAPITAL LETTERS ONLY.
ILLEGIBLE HANDWRITING AND INCOMPLETE INFORMATION WILL RESULT IN DELAYS.

EXPIRED CARDS WILL BE REJECTED

Part 1 - 125# White Tag - 4 1/4" x 11 3/4" (±1/16") - Prints Black and Red 185 Inks

Part 2 - Whatman 903 Lot WXXX
4 1/4" x 2 1/8" (±1/16")
Prints Bio Black 586 Ink
Green lines indicate pocket glue
between parts 1 & 2
with EBF Glue # 1001

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NEVER TOUCH FILTER PAPER CIRCLES
KEEP AWAY FROM ALL CONTAMINANTS

See above diagram for puncture site.Place infant's limb in a position to increase venous pressure. Warming the skin-puncture site can increase blood flow through the site. A warm moist towel at a temperature no higher than 42°C may be used to cover the site for 3 minutes.

INSTRUCTIONS FOR COLLECTING BLOOD SAMPLE

1. Complete all information using a ballpoint.
2. Using appropriate blood handling precautions, clean infant's heel with alcohol swab. Dry area.
3. Puncture heel with appropriate sterile lancet (depth ≤2.0mm). Wipe away first drop with sterile gauze.
4. Allow large drop to form. Gently touch filter (circle) paper against large drop of blood, quickly allowing blood to soak through to fill circle. Do not press against heel. Apply to only one side of paper, saturating through to reverse side.
5. Using only one large drop per circle fill all circles. EXAMINE BOTH SIDES TO ASSURE SATURATED, SINGLE DROP, NON-DAMAGED COLLECTION.
6. Elevate infant's foot above body, pressing dry sterile pad or swab until bleeding stops.
7. Air dry in suspended horizontal position at least 4 hrs. at ambient temperature making sure that blood spots do not come into contact with anything until completely dry.
8. When completely dry, cover with biohazard shield.
9. Send to state lab as soon as possible after drying (within 24 hours) to avoid delays.

ATTENTION: ALL PERSONNEL HANDLING INFANT SCREENING CARDS

These new cards contain a biohazard shield which must be flipped over the dried blood spot blotter before mailing to the state laboratory.

Note: DO NOT USE THIS BIOHAZARD SHIELD AS A SURFACE FOR DRYING!

Please continue to dry the card flat and freely open to air on all sides.

REF 10534749 REV.AE IVD

Part 1 Backer - Prints Black and 185 Red Inks

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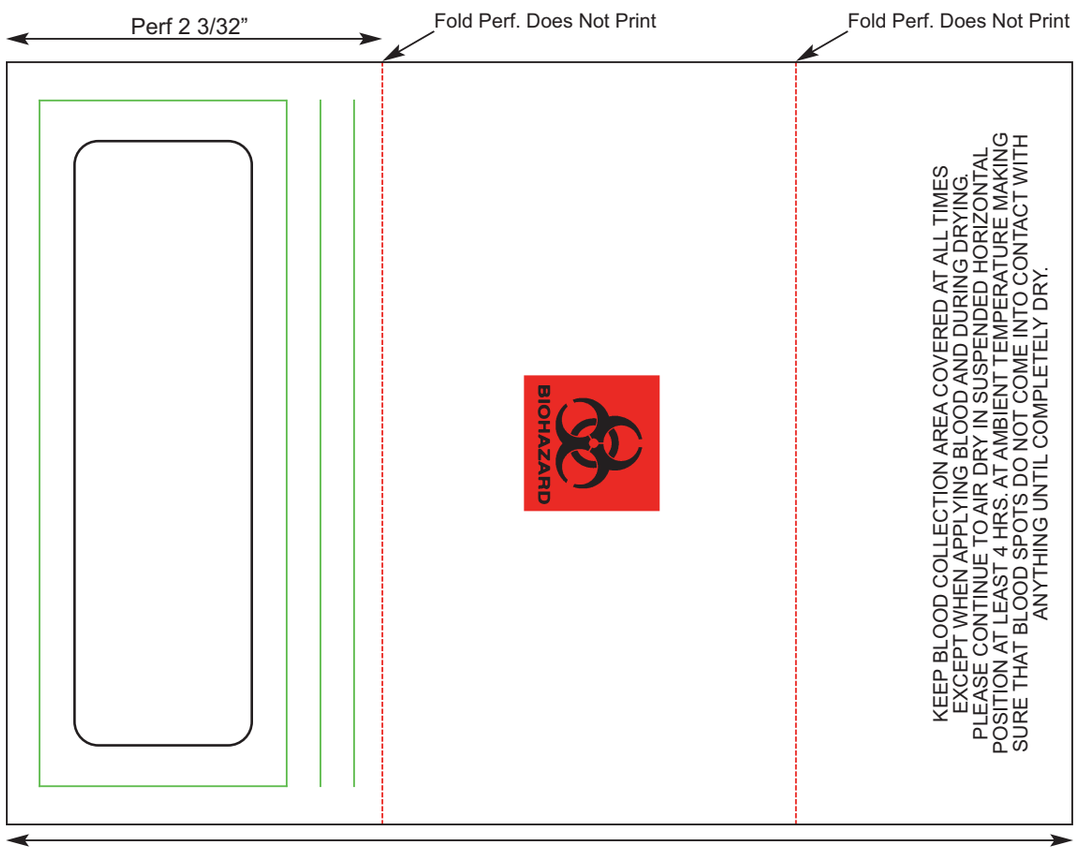

Part 3 - 125# White Tag - 4 1/4” x 5 15/16” (±1/16”) - Prints Black & 185 Red Inks

Green lines indicate pocket glue
between parts 2 & 3
with EBF Glue # 1001

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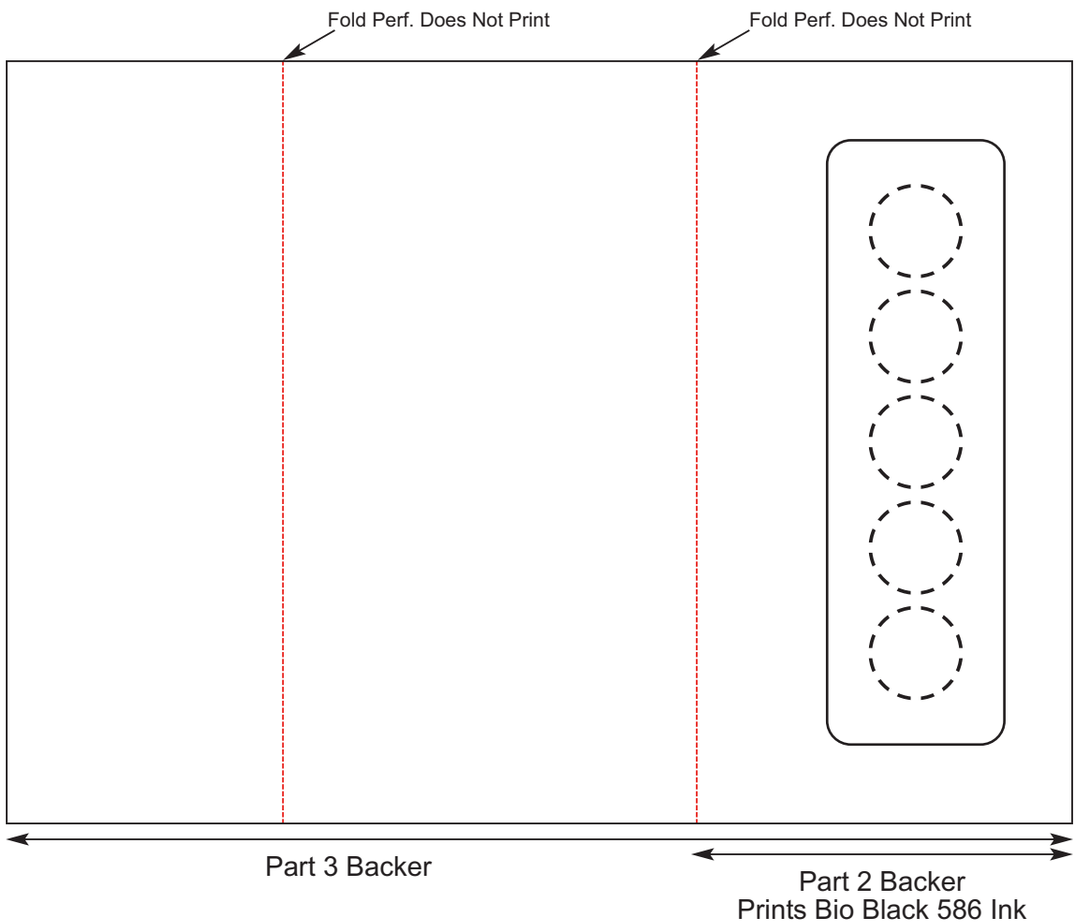
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