

HOW TO FILL OUT NEWBORN SCREENING CARDS

It is extremely important to fill out the screening card accurately and completely. Inaccurate or missing information may affect the accuracy of the screening results and/or the ability to quickly contact the baby's care provider in the event of an abnormal screening result. Any delay may put the baby's health at risk. The specimen submitter is legally responsible for the accuracy and completeness of the information on the newborn screening card.

Do NOT use this space

Infant Medical Record Number

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Baby	Last Name										First Name									
	Birth Date				Birth Time (military)				Birth Weight (grams)				Multiple Births				Gestational Weeks			
	MMDDYY				HHMM								<input type="checkbox"/> Yes <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3							
	Specimen Date of Collection				Collection Time				Type of Feeding				Sex				Risk Factors NICU patient <input type="checkbox"/> Birth defects <input type="checkbox"/> Deceased siblings <input type="checkbox"/> Family history of disorder on MN screening panel <input type="checkbox"/> Cause of death:			
	MMDDYY				HHMM				<input type="checkbox"/> Breast <input type="checkbox"/> TPN <input type="checkbox"/> Milk Formula <input type="checkbox"/> Soy Formula				<input type="checkbox"/> Male <input type="checkbox"/> Female							
	Collected By (initials)				Clinical Information				Date of Transfusion											
					<input type="checkbox"/> Antibiotics <input type="checkbox"/> Transfused				MMDDYY											

Mother	Last Name										First Name										Mother's Birth Date							
																					MMDDYY							
	Address																				City				Zip Code			
	Alternate Contact for Family (name and phone number)																State		Mother's Phone Number									

Physician	Physician/Clinic Responsible for Infant Follow-Up after Discharge																													
	Physician/Clinic Phone Number																													

Submitter	Submitter Name																				Submitter City									
	Submitter's Phone Number										Submitter #										Notes									

Minnesota Department of Health, Newborn Screening Program, 601 Robert St. N., St. Paul, MN 55155-2531, Phone: (800) 664-7772 or (651) 201-5466, Fax: (651) 215-6285



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Remember

- Please write firmly in blue or black ink to ensure that all information is transferred between carbon copies.
- Please remove the top sheet before submitting the specimen card to MDH.

Please do not place stickers/tracking labels over or write in the space at the top of the card that says, “Do NOT use this space.” *Please do not put a sticker/label over the barcode.* MDH uses this space to stamp our own identification code.

Do NOT use this space.

Infant Medical Record Number

Last Name First Name

Birth Date Birth Time (military) Birth Weight (grams) Multiple Births Gestational Weeks Risk Factors

Specimen Date of Collection Collected By (initials)

Infant Medical Record Number

Do NOT use this space

Last Name First Name

Address

Alternate Contact for Family (name and phone number) State Mother's Phone Number

Physician/Clinic Responsible for Infant Follow-Up after Discharge

Physician/Clinic Phone Number

Baby's Information

Do NOT use this space.

Infant Medical Record Number

Last Name First Name

Birth Date Birth Time (military) Birth Weight (grams) Multiple Births Gestational Weeks Risk Factors

Specimen Date of Collection Collection Time Type of Feeding Sex

NICU patient Birth defects

Deceased siblings Family history of disorder on MN screening panel

Cause of death:

Clinical Information

Antibiotics Transfused

Date of Transfusion

Collected By (initials)

Last Name First Name

Address

Alternate Contact for Family (name and phone number) State Mother's Phone Number

Physician/Clinic Responsible for Infant Follow-Up after Discharge

Physician/Clinic Phone Number

Submitter Name Submitter City

Baby medical and record number

- Please be sure to write the baby's medical record number — not the mother's

Last name and first name

- Write the baby's last name, followed by the first name.
- It is import to list the baby's last name, regardless of whether the parent(s) have chosen a first name. Do not assume the last name is the same as the mother's last name. If the parent(s) have not yet been chosen a first name, please follow your hospital/clinic's naming policy.
- The baby's name written on the newborn screening card should match the infant's name on the birth certificate.

- Providing an incorrect last name could potentially cause a delay in reporting abnormal results, impacting the health of the baby.

Birth date

- Use a six digit number (MM/DD/YY) for the baby's date of birth. For example, an baby born on January 30, 2025, would be recorded as 01/30/25.

Birth time

- Always use military time (HH:MM) when entering the time of birth.
- Tests are specific to the exact age (in hours) of the baby so an accurate birth time is crucial.

Birth weight

- Record the baby's four-digit birth **weight in grams** (e.g. 2340). *Do not* write the baby's weight at the time that the specimen was collected.
- It is important to correctly record the baby's birth weight for accurate test results.

Multiple births

- If the baby is one of a set of multiples (twins, triplets, etc.) please check the "Yes" box in the multiple birth sections.
- It is important to indicate the birth order of the baby. For example, if the baby is born in a set of triplets, check the "Yes" and "1" boxes. For the third baby, check the "Yes" and "3" boxes.
- Please do not fill out this section unless baby is a multiple.

Gestational weeks

- Record the baby's week of gestation at the time of birth; accurate gestational age is critical for analyzing the results of newborn screening tests.

Specimen date of collection

- Use a six-digit number (MM/DD/YY) for the date that the specimen was collected.

Collection time

- Always use military time (HH:MM) when recording the time of specimen collection.
- The time of collection is important for our lab to know because many tests are specific to the baby's exact age in hours at the time the specimen was collected. An incorrect time of collection could lead to a false negative or false-positive result.

Type of feeding

- Check all types of feeding that apply. For example, if the baby is receiving both TPN and breast milk, check both boxes.

Sex

- Check the appropriate box to indicate whether the baby's sex is male or female.

Collected by (initials)

- Record the initials of the person collecting the specimen.

Clinical information

- If the baby was transfused or received antibiotics, check the appropriate box. This information is crucial for accurately interpreting test results.

Date of transfusion

- If the baby was transfused, please provide the most recent date of transfusion.

Risk factors

- Check the appropriate box if any of these situations apply. If any boxes are checked, please elaborate in the space provided in the “Risk Factors” box in the “Notes” section at the bottom of the card.
 - If the baby has any deceased siblings, please write the cause of death for the sibling.
 - If the baby has any birth defects (such as a cleft lip/palate, Down syndrome, heart defects, etc.) please write these in the box.
 - If the baby’s family has a history of a disorder on the Minnesota screening panel, please write down which disorder applies.

Mother/Guardian Information

The form is divided into four main sections: Baby, Mother, Physician, and Submitter. The Baby section includes fields for Specimen Date of Collection, Collection Time, Type of Feeding (Milk Formula, Breast, TPN, Soy Formula), Sex (Male, Female), and Date of Transfusion. It also has checkboxes for NICU patient, Birth defects, Deceased siblings, and Family history of disorder on MN screening panel. The Mother section includes fields for Last Name, First Name, Mother's Birth Date, Address, City, Zip Code, Alternate Contact for Family (name and phone number), State, and Mother's Phone Number. The Physician section includes fields for Physician/Clinic Responsible for Infant Follow-Up after Discharge and Physician/Clinic Phone Number. The Submitter section includes fields for Submitter Name, Submitter's Phone Number, and Minnesota Department. A barcode with the number 0517696012 is located on the left side of the form. A large box highlights the Mother's information fields, and an arrow points from the 'Cause of death' field to the 'Alternate Contact for Family' field.

Last name and first name

- Record the mother/guardian’s last name followed by their first name.
- In the event of a surrogacy or adoption, please record the name of the adoptive parent/guardian here.
- Accurate identifying information is crucial for contacting the parent/guardian in the event of an abnormal result or a need for retesting.

Mother’s birth date

- Use a six-digit number (MM/DD/YY) for the mother/guardian’s date of birth.
- In the event of a surrogacy or adoption, please write the date of birth of the adoptive parent/guardian.

Address

- Record the parent/guardian’s current street address, city, and zip code.
- In the event of a surrogacy or adoption, please record the address of the adoptive parent/guardian here.
- Accurate contact information is crucial for contacting the parent/guardian in the event of an abnormal result or a need for retesting.

Alternative contact for family (name and phone number)

- This may be helpful in the event that the family does not have a permanent home address or access to a telephone.
- Record the name and phone number for an alternative contact person for the family. This person may be a friend or relative who can contact the family immediately
- If a baby was born via surrogacy, use the name of the parent/guardian who will be caring for the baby after delivery.
- In the event of an adoption, please record the name and phone number of the case worker here.
- If the baby will be held in protective services, record the name and phone number of the baby's social worker.
- Accurate contact information for an alternate contact is important in ensuring that the baby can receive follow-up testing and/or care in the event of an abnormal result and the parent/guardian cannot be reached.

State

- Record the parent/guardian's current state of residence.
- In the event of a surrogacy or adoption, please record the state of residence of the adoptive parent/guardian here.

Mother's phone number

- Record the mother/guardian's phone number (including area code) at which they can be most easily reached in case of emergency.
- In the event of a surrogacy or adoption, please record the phone number of the adoptive parent/guardian here.

Physician's Information

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Baby	Birth Date	Birth Time (military)	Birth Weight (grams)	Multiple Births	Gestational Weeks	Risk Factors
Specimen Date						
Collected By (initials)						
Mother						
Last Name						
Address						
Alternate Contact for Family (name and phone number)					State	Mother's Phone Number
Physician	Physician/Clinic Responsible for Infant Follow-Up after Discharge					
	Physician/Clinic Phone Number					
Submitter	Submitter Name				Submitter City	
	Submitter's Phone Number				Submitter #	
	Notes					

Physician/clinic responsible for infant follow-up after discharge

- Provide the name of the baby's primary care provider/clinic.
- If the provider is not known at the time of specimen collection, be sure to write down the name of the clinic where the parent/guardian plan to take the newborn for their first well-child check.

- This is also the physician/clinic who will receive the newborn screening results from the submitting facility/provider.
- Do not write the name of the provider who rounded on the newborn in the hospital.
- Correctly recording this information is critical. MDH needs the name of the primary care to make sure follow-up of abnormal result is completed.

Physician/clinic phone number

- Provide the phone number (including area code) for the baby's primary care physician/clinic.
- This information is used to contact the physician/clinic with abnormal test results and follow-up information.

Submitter Information

The form includes sections for Baby, Mother, Physician/Clinic, and Submitter information. The Submitter section is highlighted with a red box, containing fields for Submitter Name, Submitter's Phone Number, Submitter #, and Submitter City. A red arrow points from the Submitter's Phone Number field to the Physician/Clinic Phone Number field. Another red arrow points from the Submitter City field to the Submitter City field in the Submitter section.

Submitter name

- Record the name of the birth hospital, clinic, and/or midwife who collected the specimen.

Submitter city

- Write the name of the city where the submitter is located (this is vital due to institutions having the same name and/or larger affiliation).

Submitter phone number

- Record the submitter's telephone number, including area code.

Submitter

- All hospitals, clinics and midwives that submit newborn screening specimen should have an assigned submitter number. This number must be recorded in the box provided. The submitter number is used to link newborn screening reports to the submitter so that MDH can return the results to the correct location.
- Contact MDH NBS Operations if you do not have a submitter number or do not know your facility's submitter number.