EXPIRATION DATE 2022-04-30

Use black or blue ink ball point pen only.

See full instructions for completion of form on back page.

SN 1899064

ODH #450 REV 04.2019

SN 1899064

Oklahoma Newborn Screening (NBS) Form

To order forms, call the OSDH NBS Program (405) 271-5070

DO NOT WRITE HERE

☐ First Screen ☐ Repeat Screen Previous NBS Lab#_____

Not Screened Due To ☐ Refused ☐ Expired ___/___/___

☐ Transferred ___/___/___ to _____

Tests Requested ☐ All Tests ☐ HGB Only ☐ GALT ☐ Phe Monitor ☐ CFTR

BABY'S INFORMATION

Last Name | First Name

Birth Date ___/___/___ Time ___:___ (24 Hr Clock)

Collection Date ___/___/___ Time ___:___ (24 Hr Clock)

Sex ☐ Male ☐ Female ☐ Unknown

Race (Check all that apply) ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

Medical Record # | Gest. Age | Birth Wt. (gm) | Multiple Birth Order ☐ A-H

MOTHER'S/GUARDIAN'S INFORMATION

☐ DHS Custody ☐ Adoption | Last Name | First Name

Address | Apt. #

City | State | Zip

Telephone # ( ) -

Alternate Telephone # ( ) -

Mother's Date of Birth ___/___/___ | Mother's Medicaid ID # | Mother's Last 4 of SSN

PROVIDER'S INFORMATION

Physician Ordering NBS (Last, First) | Provider ID#

Primary Care/Follow-up Physician (Last, First) | Provider ID #

MEDICAL/FEEDING HISTORY (Check all that apply)

☐ Transfusion Date ___/___/___ Time ___:___ (24 Hr Clock)

☐ NICU/SCN ☐ TPN/SNAP ☐ Lipids/Carnitine/MCT

☐ Lactose-Free Formula (Soy) ☐ Meconium Ileus ☐ Family History of CF

PULSE OXIMETRY/CCHD SCREEN

☐ Pass ☐ Fail ☐ Not Performed ☐ Refused ☐ Echo

Do not write in this box

HEARING SCREEN

Date of Final Screen ___/___/___

Right Ear: ☐ Pass ☐ Refer Left Ear: ☐ Pass ☐ Refer

Screen Method ☐ ABR ☐ OAE

If not screened, reason ☐ Delayed ☐ Discharged ☐ No Supplies ☐ Refused ☐ Technical Problem

Hearing Risk Status (Select all that apply) ☐ Family History ☐ In Utero Infection ☐ Craniofacial Anomalies ☐ ECMO ☐ Both Hyperbilirubinemia AND Exchange Transfusion ☐ NICU

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #

Submitter's Name/Address

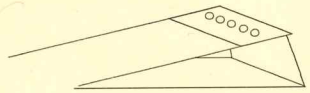
DETACH AND PLACE IN MEDICAL RECORD

DO NOT REMOVE THIS COVER FLAP

OPEN this flap to uncover the circles for blood collection. DO NOT touch circles.

OPEN this flap while blood spots are drying.

- Air-dry blood spots at room temperature for 3-4 hours.
- Flap can be used to support filter paper horizontally while drying.



Close this flap over blood spots when completely dry.

BIOHAZARD

DETACH AND GIVE TO PARENT OR GUARDIAN

DETACH AND GIVE TO PARENT OR GUARDIAN

CHART COPY

DETACH AND PLACE IN MEDICAL RECORD

Oklahoma Newborn Screening (NBS) Form

To order forms, call the OSDH NBS Program (405) 271-5070

DO NOT WRITE HERE

SN 1899064

☐ First Screen ☐ Repeat Screen Previous NBS Lab# _____

Not Screened Due To ☐ Refused ☐ Expired ___/___/___ ☐ Transferred ___/___/___ to _____

Tests Requested ☐ HGB Only ☐ Phe Monitor ☐ All Tests ☐ GALT ☐ CFTR

MEDICAL/FEEDING HISTORY *(Check all that apply)*

☐ Transfusion Date ___/___/___ Time ___:___ *(24 Hr Clock)*
☐ NICU/SCN ☐ TPN/SNAP ☐ Lipids/Carnitine/MCT
☐ Lactose-Free Formula (Soy) ☐ Meconium Ileus ☐ Family History of CF

BABY'S INFORMATION

Last Name | First Name

Birth Date ___/___/___ Time ___:___ *(24 Hr Clock)* | Sex ☐ Male ☐ Female ☐ Unknown | Race *(Check all that apply)* ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ American Indian ☐ Pacific Islander

Collection Date ___/___/___ Time ___:___ *(24 Hr Clock)* | Gest. Age | Birth Wt. (gm) | Multiple Birth Order ☐ A-H

MOTHER'S/GUARDIAN'S INFORMATION

Medical Record # | ☐ DHS Custody ☐ Adoption | Last Name | First Name

Address | Apt. #

City | State | Zip

Telephone # ( ) - | Alternate Telephone # ( ) - | Mother's Last 4 of SSN

Mother's Date of Birth ___/___/___ | Mother's Medicaid ID #

PULSE OXIMETRY/CCHD SCREEN

☐ Pass ☐ Fail ☐ Not Performed ☐ Refused ☐ Echo

Do not write in this box

HEARING SCREEN

Date of Final Screen ___/___/___

Right Ear: ☐ Pass ☐ Refer | Left Ear: ☐ Pass ☐ Refer

Screen Method ☐ ABR ☐ OAE

If not screened, reason ☐ Delayed ☐ Discharged ☐ No Supplies ☐ Refused ☐ Technical Problem

Hearing Risk Status *(Select all that apply)*
☐ Family History
☐ In Utero Infection
☐ Craniofacial Anomalies
☐ ECMO
☐ Both Hyperbilirubinemia AND Exchange Transfusion
☐ NICU

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #

Submitter's Name/Address

PROVIDER'S INFORMATION

Physician Ordering NBS (Last, First) | Provider ID#

Primary Care/Follow-up Physician (Last, First) | Provider ID #

Use black or blue ink ball point pen only.

See full instructions for completion of form on back page.

EXPIRATION DATE 2022-04-30

ODH #450 REV 04.2019

SN 1899064

SN 1899064

Oklahoma Newborn Screening (NBS) Form

To order forms, call the OSDH NBS Program (405) 271-5070

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Not Screened Due To ☐ Refused ☐ Expired ___/___/___
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Medical Record # | Gest. Age | Birth Wt. (gm) | Multiple Birth Order ☐ A-H

MOTHER'S/GUARDIAN'S INFORMATION

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Telephone # ( ) - | Alternate Telephone # ( ) -

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PROVIDER'S INFORMATION

Physician Ordering NBS (Last, First) | Provider ID#

Primary Care/Follow-up Physician (Last, First) | Provider ID #

MEDICAL/FEEDING HISTORY (Check all that apply)

☐ Transfusion Date ___/___/___ Time ___:___ (24 Hr Clock)
☐ NICU/SCN ☐ Lactose-Free Formula (Soy)
☐ TPN/SNAP ☐ Meconium Ileus
☐ Lipids/Carnitine/MCT ☐ Family History of CF

PULSE OXIMETRY/CCHD SCREEN

☐ Pass ☐ Fail ☐ Not Performed ☐ Refused ☐ Echo

Do not write in this box

HEARING SCREEN

Date of Final Screen ___/___/___

Right Ear: ☐ Pass ☐ Refer Left Ear: ☐ Pass ☐ Refer

Screen Method ☐ ABR ☐ OAE

If not screened, reason ☐ Delayed ☐ Discharged ☐ No Supplies ☐ Refused ☐ Technical Problem

Hearing Risk Status (Select all that apply) ☐ Family History ☐ In Utero Infection ☐ Craniofacial Anomalies ☐ ECMO ☐ Both Hyperbilirubinemia AND Exchange Transfusion ☐ NICU

SUBMITTER'S INFORMATION

Submitting Facility's/Provider's ID #

Submitter's Name/Address

CHART COPY

DETACH AND PLACE IN MEDICAL RECORD

DETACH AND GIVE TO PARENT OR GUARDIAN

DETACH AND GIVE TO PARENT OR GUARDIAN

SN 1899064

OKLAHOMA NEWBORN SCREENING PROGRAM

Oklahoma State Department of Health

Parent/Guardian Information Sheet

Baby's Last Name | Baby's First Name

Newborn screening blood tests

Every baby born in Oklahoma is required to have blood tests performed during the first week of life in order to help in the early detection of a group of treatable medical conditions that can cause severe illness, developmental disability or death. These tests can all be performed using a small amount of blood usually collected when the baby is 24 to 48 hours old. The blood sample is sent to the Oklahoma State Department of Health (OSDH) Public Health Laboratory for testing. Test results are usually available in 10-14 days. For a list of conditions that are screened for in Oklahoma, see the OSDH Newborn Screening Program website at http://nsp.health.ok.gov

Importance of newborn screening

A baby with one of the conditions in the newborn screening test panel may appear healthy at birth, which makes it difficult for healthcare providers to recognize clinically. Failure or delay in diagnosing and treating a baby with one of these conditions within weeks of life can lead to severe illness or death. Newborn screening blood tests help inform healthcare providers if your baby is at risk for one of these conditions. If your baby is found to have a disorder, immediate care by a medical specialist may be needed.

How will I get the test results for my baby?

Please, take this form with you to your baby's first well child visit and ask for your baby's newborn screening test results. If your baby's healthcare provider does not have the test results and you have not been notified by mail, please call the OSDH Newborn Screening Program at the number indicated on the reverse of this form when your baby is 3 weeks of age.

DETACH AND GIVE TO PARENT OR GUARDIAN

DETACH AND GIVE TO PARENT OR GUARDIAN

SN 1899064

OKLAHOMA NEWBORN HEARING SCREENING PROGRAM

Oklahoma State Department of Health

Parent/Guardian Information Sheet

DETACH AND GIVE TO PARENT OR GUARDIAN

Baby's Last Name	Baby's First Name

IMPORTANT
Please, take this form with you to your baby's first well child visit to discuss the results with your baby's healthcare provider.

Importance of newborn hearing screening

Every baby born in an Oklahoma hospital is required to have their hearing checked before leaving the hospital. For infants born outside of a hospital, a screening should be completed no later than 1 month of life. Hearing screening is a quick, harmless and effective way to determine if an infant can hear sounds needed for proper development of speech and language. Hearing problems need to be identified as early as possible. If an infant has a hearing loss, steps can be taken to help the infant learn to communicate.

HEARING SCREEN

Date of Final Screen ___ / ___ / ___

Right Ear: ☐ Pass ☐ Refer Left Ear: ☐ Pass ☐ Refer

Screen Method
☐ ABR ☐ OAE

If not screened, reason
- ☐ Delayed
- ☐ Discharged
- ☐ No Supplies
- ☐ Refused
- ☐ Technical Problem

Hearing Risk Status
(Select all that apply)
- ☐ Family History
- ☐ In Utero Infection
- ☐ Craniofacial Anomalies
- ☐ ECMO
- ☐ Both Hyperbilirubinemia AND Exchange Transfusion
- ☐ NICU

Will my baby need more testing?

The hearing screen results for your baby should be indicated in the box to the right.

- **"Pass"** for both ears = your infant's hearing is sufficient for language development
- **"Refer"** for one or both ears = additional testing is needed. Your baby's healthcare provider should refer you for additional hearing testing.

Hearing loss can occur at any time after birth. If your baby has any box marked under **Hearing Risk Status**, it is recommended that your baby's hearing be checked again by 6 months of age.

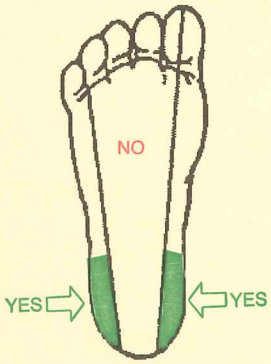
If for some reason your baby's hearing was not screened, please call the Oklahoma State Department of Health Newborn Hearing Screening Program at the number indicated on the reverse of this form to ask about a location close to you where your baby's hearing can be checked.

SN 1899064 903™ LOT 7144919 W181 EXPIRATION DATE 2022-04-30 COLLECTOR'S INITIALS _____ UNIT _____

Instructions for Collecting Blood Spot Specimens

Note: *Do not handle blood collection area of Newborn Screening Form before, during, or following sampling.*

Collect blood sample from outer or inner border of heel



Collection of poor quality specimens will delay testing

CORRECT / ACCEPTABLE

Circles filled and evenly saturated

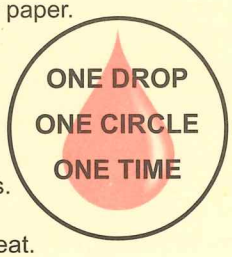
WRONG / UNACCEPTABLE

Multiple applications/layering

Multiple applications/insufficient sample

Serum rings present

1. Position infant's foot lower than rest of body to increase blood flow.
2. Warm heel using heel warmer or a soft cloth moistened with warm water up to 41ºC for 3 to 5 minutes.
3. Clean infant's heel with 70% isopropyl alcohol and allow to air-dry.
4. Puncture inner or outer border of the heel with sterile disposable lancet, using a single, firm, quick puncture.
5. Allow a large drop of blood to accumulate then wipe away with sterile gauze.
6. Gently massage above the puncture site so blood flows freely; do not squeeze heel since interstitial fluid will contaminate the sample.
7. Allow a second large drop of blood to accumulate.
8. Apply one large drop of blood to a circle on the filter paper; the circle should be COMPLETELY filled when viewed from both sides of the filter paper.
   - Do not layer successive drops of blood.
   - Do not touch filter paper to the collection site.
   - Do not apply blood to both sides of filter paper.
9. Repeat procedure for each circle, filling all 5 circles.
10. Enter initials of person collecting sample and unit on filter paper.
11. Allow blood spots to air-dry at room temperature for 3-4 hours.
    - Dry horizontally, preferably in a drying rack.
    - Keep away from direct light (sun or lamps) and artificial heat.
    - Keep protective flap open during drying.
    - Do not let blood spots touch anything.
    - Do not allow wet spots to come in contact with each other.
12. When completely dry, fold protective flap over blood spots.
13. Place completed NBS form in PAPER envelope for transport to testing laboratory. Do not put specimens in plastic bags.



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INSTRUCTIONS FOR COMPLETION OF HEARING SCREEN SECTION OF NBS FORM

Hearing screening results should be submitted at the same time as the blood specimen whenever possible. No more than 2 quality screening attempts should be performed. If the hearing screen will be delayed, DO NOT delay sending the blood specimen. ALL BLOOD SPECIMENS MUST BE SENT WITHIN 24 HOURS OF COLLECTION.

Hearing Screen

1. Screen the infant's hearing using the available technology.
2. Enter hearing screen information on the right side of the NBS Form under "Hearing Screen".
3. Provide Date of Final Screen.
   Note: *Hospitals should only provide the final hearing screening results. If a second screen is required, report ONLY the second/final screen results.*
4. Indicate Right Ear and Left Ear results utilizing "x."
   Note: *Ensure only one result is selected per ear. To make corrections, use a single line through the incorrect result. Print the word "error" and initial the change. (e.g., x ~~Refer~~ Error AB)*
5. Indicate Screen Method used.

Reason Not Screened

Note: *If infant is screened disregard this section.*

1. If hearing screen cannot be performed, indicate the reason by selecting the appropriate box in the "If not screened, reason" section.
   a. Delayed - if a hearing screen cannot be completed before the blood specimen is sent and it is anticipated that hearing will be screened prior to discharge (e.g., infant in NICU).
   b. Discharged - if infant discharged before a hearing screen can be performed.
   c. No supplies - if no supplies are available for the hearing screen.
   d. Refused - if the parents/guardian refused a hearing screen.
   e. Technical Problem - if a technical issue prevented performance of a hearing screen.
   Note: *If a technical problem occurs, report issue to the Newborn Hearing Screening Program.*
2. Complete the "Hearing Risk Status" section (see below).
3. Ensure there are no marks in the "Screen Method" box.
4. Detach and retain the Chart copy (yellow sheet) and Hearing Screening Parent/Guardian Information Sheet (pink sheet) of the NBS form.
5. Submit the NBS Form and blood specimen for testing.
6. Perform the hearing screen prior to discharge.
7. Record the hearing screen results in the appropriate boxes on both the yellow Chart copy and pink Parent/Guardian copy.
   a. If a new Hearing Risk Status becomes available, indicate in appropriate boxes on both copies
   b. Photocopy the front of the completed yellow Chart copy; photocopy is used to fax results.
   Note: *Be certain infant's name and NBS Form Serial Number are legible on the photocopy.*
8. Fax a copy of the results to the Newborn Hearing Screening Program at 405-271-4892.

Hearing Risk Status

Complete the "Hearing Risk Status" section by selecting all that apply, if known.
Note: *This may require reviewing the patient's chart or asking about family history.*

a. Family History - if blood relatives of the infant have a permanent hearing loss that began in early childhood (e.g., parent, grandparent, cousin, etc.).
b. In Utero Infection - If infant exposed to CMV, herpes, rubella, syphilis, toxoplasmosis, Zika, etc.
c. Craniofacial Anomalies - if infant displays pinna/ear canal malfunctions (microtia, atresia, ear dysplasia), cleft palate, microcephaly, hydrocephalus, etc.
d. ECMO - if extracorporeal membrane oxygenation administered to infant.
e. Both Hyperbilirubinemia AND Exchange Transfusion - if infant has hyperbilirubinemia requiring exchange transfusion; must have both to select this risk factor.
f. NICU - If infant in NICU or special care nursery.

Parent Education

Detach the Hearing Screening Parent/Guardian Information Sheet (pink sheet) and give to the infant's parent or guardian at discharge. Discuss taking the form to the baby's healthcare provider.

SEND SPECIMENS WITHIN 24 HOURS OF COLLECTION

Use OSDH Courier Service or mail via USPS to:

Newborn Screening
Oklahoma State Dept. Health
Public Health Laboratory
P.O. Box 24106
Oklahoma City
OK 73124-0106

INQUIRIES

NBS Public Health Lab:
(405) 271-5070

NBS Follow-up:
(405) 271-6617 or
(800) 766-2223

ORDERING NBS FORMS

Call (405) 271-5070
http://phl.health.ok.gov

STORAGE

Store NBS forms vertically in a clean, dry area, away from direct sunlight before and after sample collection.

INSTRUCTIONS FOR COMPLETION OF NBS FORM

Print legibly using a black or blue ball point pen; press hard to ensure transfer to all copies of form.
Illegible writing and incomplete information may delay test results.
Complete form, even if specimen is not collected.

Top-left Portion of Form

Indicate if this is a First or Repeat newborn screen. Provide previous NBS Lab #, if known.
If infant is not screened, indicate reason. If deceased, provide Date Expired.
If transferred to another hospital, provide Date Transferred and Receiving Hospital.
Indicate Tests Requested, as appropriate.

Baby's Information (as entered on birth certificate, as applicable)

Provide infant's Last Name and First Name(s).
Write "Male or "Female" as First Name ONLY if first name is unknown.
Provide Birth Date and Time of Birth (use 24 hour clock, e.g., 8:30 AM is 0830 and 9:01 PM is 2101).
Provide Date and Time of Collection of specimen (use 24 hour clock).
Note: *Specimens should be collected as early as possible after 24 hours of birth, prior to blood transfusion, or immediately prior to discharge, whichever comes first.*
Indicate Sex of infant.
Indicate Race of infant, by selecting all that apply.
Provide infant's Medical Record number, as used by facility collecting specimen.
Provide Gestational Age (in weeks) of infant at time of birth.
Provide Birthweight (in grams) of infant.
If multiple birth, provide birth order for infant, using A (1st) through H (8th).

Mother's/Guardian's Information

Mark whether infant is in DHS Custody or is up for Adoption, as appropriate.
Provide Mother's/Guardian's Last Name and First Name.
Note: *If infant is to be adopted, document the name of the agency or law firm handling adoption, or Legal Guardian responsible for infant's care at time of discharge.*
Provide full address of Mother/Guardian.
Provide primary and secondary Telephone #s in the event that follow-up is required.
Secondary phone can be that of father or other close relative.
Provide Mother's Date of Birth, Medicaid ID# and Last 4 Digits of her Social Security #.

Provider's Information

Provide Last Name and First Name and NBS Provider ID# of physician (or midwife) who is ordering this screen. Refer to OSDH NBS Provider's ID list for full listing of providers.
Provide Last Name and First Name and NBS Provider ID# of physician who will be responsible for follow-up care of infant after discharge. If infant will be hospitalized for an extended period of time then provide name of attending physician.

Submitter's Information

Provide Submitting Facility's or Provider's NBS ID #.
Provide Submitter's Name and Address (e.g., birthing hospital).

Medical/Feeding History

If infant has been transfused, provide Date and Time of Transfusion.
Indicate if infant is in NICU or Special Care Nursery (SCN).
Indicate feeding and medical history, as appropriate.

Pulse Oximetry/CCHD Screen

Indicate pulse oximetry result as appropriate.
Note: *A response should be provided on every filter paper.*
If not screened, mark "Not Performed." If echo is performed in lieu of screening, mark "Echo."

Hearing Screen

See Hearing Screen Instructions section of this form.