



Phone 864.299.8787
Toll Free 866.757.8334 Fax. 864.299.8797

Form Name	Illinois NBS Neonatal Card
Design ID	ILNB20120207008
Version	008
Design Date	02/07/12 GG

Approved

Not Approved

Signature

Print Name

Date

Changes from previous job 1001290

1. Added Spanish copy as part 2 to form
2. Changed "SSN" field to only 4 boxes, moved to beside "DOB" field
3. Added text "(last 4 digits only)" under "SSN"
4. Added "Baby's ID" field to bottom of Baby's Information section
5. Increased boxes from 2 to 3 in "Gestational Age" field
6. Added check box for "Meconium Ileus"
7. Added phrase "USE BLACK INK ONLY" to bottom of the demographic sections and back of the form.
8. Updated starting number to ILX0000001x
9. Updated lot and job number, and expiration date
10. Updated regulatory information and symbols

Changes from ver.007

11. Added 4 boxes to Baby's ID field and spaced out the screened lettering

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Dotted Magenta lines signify perf lines.



Magenta circles signify line holes.

Front of Form (Flap Folded)

All measurements can vary +/- 1/16" (1.6mm)
Glue lines are between the stubs of parts 1, 2, 3, 4 and 6, and in between parts 4 and 5

INSTRUCTIONS TO HOSPITAL: Remove this top sheet and give to parent.

Illinois Department of Public Health
Genetics/Newborn Screening Program
535 W. Jefferson, 2nd Floor
Springfield, Illinois 62761
217-785-8101

PARENT INFORMATION SHEET

Dear Parent,

A blood sample has been taken from your baby's heel to test for rare, but serious disorders, which can cause mental retardation, poor growth, or death, if not treated. The pamphlet "A Baby's First Step in Life" describes the mandated Illinois newborn screening tests. If you have not received this pamphlet, ask your baby's physician, nurse, or other health care provider for a copy.

It is important that your hospital and your baby's doctor have your correct name and phone number in case your baby needs another test or to be seen by a specialist. If your baby's test is done before he or she is 24 hours old, ask your child's primary care provider to repeat the newborn screening test within 1-2 days.

The Illinois Department of Public Health Newborn Screening Program office will report test results to the hospital, doctor, midwife, or individual who submitted the test. If a repeat test is needed, the Program will notify the health care provider who submitted the sample. If the test is positive, the Program office may also notify a treatment center that may contact you directly. If you have questions, speak to your baby's doctor, contact the Department's Newborn Screening Program, or visit the Department's Web site at www.idph.state.il.us.

AL
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(MILITARY TIME)
ON
(MILITARY TIME)
ECONIUM
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**This flap should not
touch blood spot
when wet.**

Total Form Height (All Parts)
6" (152.4mm)

SEE DIRECTIONS ON REVERSE SIDE

← Total Form Length (flap folded) 10" (254.0mm) →
← stub = 1/2" →

Total Form Length (flap folded)
10" (254.0mm)



ID0214_Rev3 11-Aug-2011

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Face of Part 1 (no copy on back)

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SEE DIRECTIONS ON REVERSE SIDE

Total Form
 Height (All Parts)
 6" (152.4mm)

Part 1: 15# Green Bond, Black ink face only
 8" (203.2mm)

stub = 1/2"



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Face of Part 2 (no copy on back)

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 Genetics/Newborn Screening Program
 535 W. Jefferson, 2nd Floor
 Springfield, Illinois 62761
 217-785-8101

HOJA DE INFORMACIÓN PARA LOS PADRES DE FAMILIA

Estimados padres:

Se ha tomado una muestra de sangre del talón de su bebé para analizarla a fin de detectar trastornos raros pero graves, los cuales pueden limitar el crecimiento del niño u ocasionar enfermedades, retrasos mentales o hasta la muerte si no reciben el tratamiento adecuado. La hoja de datos «Los primeros pasos en la vida de un bebé» describe los análisis médicos para recién nacidos que requiere la ley de Illinois. Si ustedes no han recibido esta hoja de datos, pídanse al médico, enfermero u otro proveedor de atención médica, o escojan *Newborn Screening* (Análisis médico para recién nacidos) de la lista en orden alfabético que aparece en la parte superior de la página de Internet del Departamento de Salud Pública de Illinois en <http://www.idph.state.il.us>.

Es importante que el hospital y el médico del bebé sepan su nombre y número telefónico correcto por si acaso su bebé necesite otro análisis o necesite ser revisado por un especialista. Si el análisis de su bebé se realiza antes de las 24 horas de nacido, pidan al proveedor de atención médica de su bebé que repita el análisis para recién nacidos no más de uno o dos días después del nacimiento.

El personal del *Newborn Screening Program* (Programa de Análisis para Recién Nacidos) del Departamento de Salud Pública de Illinois informará al hospital, médico, partera u otro individuo que entregó la muestra, sobre los resultados del análisis. Si se necesita un análisis repetido, el programa informará al proveedor de atención médica que entregó la muestra. Si el análisis da resultados positivos de algún trastorno, el programa también puede informar a un centro de tratamiento que tal vez se comunique con ustedes directamente. Si ustedes tienen preguntas, hablen con el médico de su bebé, contacten al *Newborn Screening Program* o visiten la página de Internet del Departamento de Salud Pública en la dirección ya mencionada para más información.

Total Form
 Height (All Parts)
 6" (152.4mm)

Part 2: 15# Canary Bond, Black ink face only
 8" (203.2mm)

stub = 1/2"




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Face of Part 3 (no copy on back)

<p>ILLINOIS DPH NEWBORN SCREENING Public Health Laboratory 2121 W. Taylor St., Chicago, IL 60612</p>				<p>DO NOT WRITE IN THIS SPACE</p>							
<p>BABY'S INFORMATION</p> <p>LAST NAME </p> <p>FIRST NAME </p> <p>CHART NUMBER </p> <p>BABY'S ID </p>				<p>GENDER</p> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> UNK		<p>RACE OF BABY</p> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native Amer. <input type="checkbox"/> UNK <input type="checkbox"/> Asian/Pacific Is.		<p>ETHNICITY OF BABY</p> <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> UNK		<input type="checkbox"/> INITIAL <input type="checkbox"/> RETEST <input type="checkbox"/> HOMEBIRTH	
<p>MOTHER'S INFORMATION</p> <p>LAST NAME </p> <p>FIRST NAME </p> <p>SSN (last 4 digits only) </p> <p>DOB MM / DD / YY </p> <p>PHONE () - </p> <p>ADDRESS </p> <p>CITY </p> <p>ST ZIP </p> <p>COUNTY </p>				<p>FEEDING</p> <input type="checkbox"/> BREAST <input type="checkbox"/> SOY <input type="checkbox"/> TPN <input type="checkbox"/> CARNITINE <input type="checkbox"/> NPO <input type="checkbox"/> OTHER		<p>BIRTH DATE</p> <p>MM / DD / YY </p> <p>SPECIMEN DATE OF COLLECTION</p> <p>MM / DD / YY </p> <p>TRANSFUSED DATE</p> <p>MM / DD / YY </p>		<p>TIME OF BIRTH (MILITARY TIME)</p> <p>HH : MM </p> <p>TIME OF COLLECTION (MILITARY TIME)</p> <p>HH : MM </p>		<input type="checkbox"/> NICU / SPECIAL CARE <input type="checkbox"/> MECONIUM ILEUS <input type="checkbox"/> ANTIBIOTIC <input type="checkbox"/> ERT	
<p>BIRTH WEIGHT (grams) </p>		<p>GESTATIONAL AGE </p>		<p>BIRTH # & ORDER</p> <input type="checkbox"/> SINGLE BIRTH <input type="checkbox"/> MULTIPLE (1,2,3)		<p>COLLECTOR </p>					
<p>BABY'S PHYSICIAN NAME & PHONE NUMBER</p> <p> </p> <p>() - </p>				<p>HOSP SUBMITTER </p>		<p>CITY </p>		<p>ID </p>			
				<p>ILX0000001x </p>		<p>USE BLACK INK ONLY</p>					

Total Form Height (All Parts)
6" (152.4mm)

Part 3: 16# White CB, Red 185 ink and black ink face only, red lines screened at 70%, red text screened at 15%, Barcode 3 of 9 with Human Readable with Mod 43 Check Digit
8 1/2" (215.9mm)

stubs = 1/2"

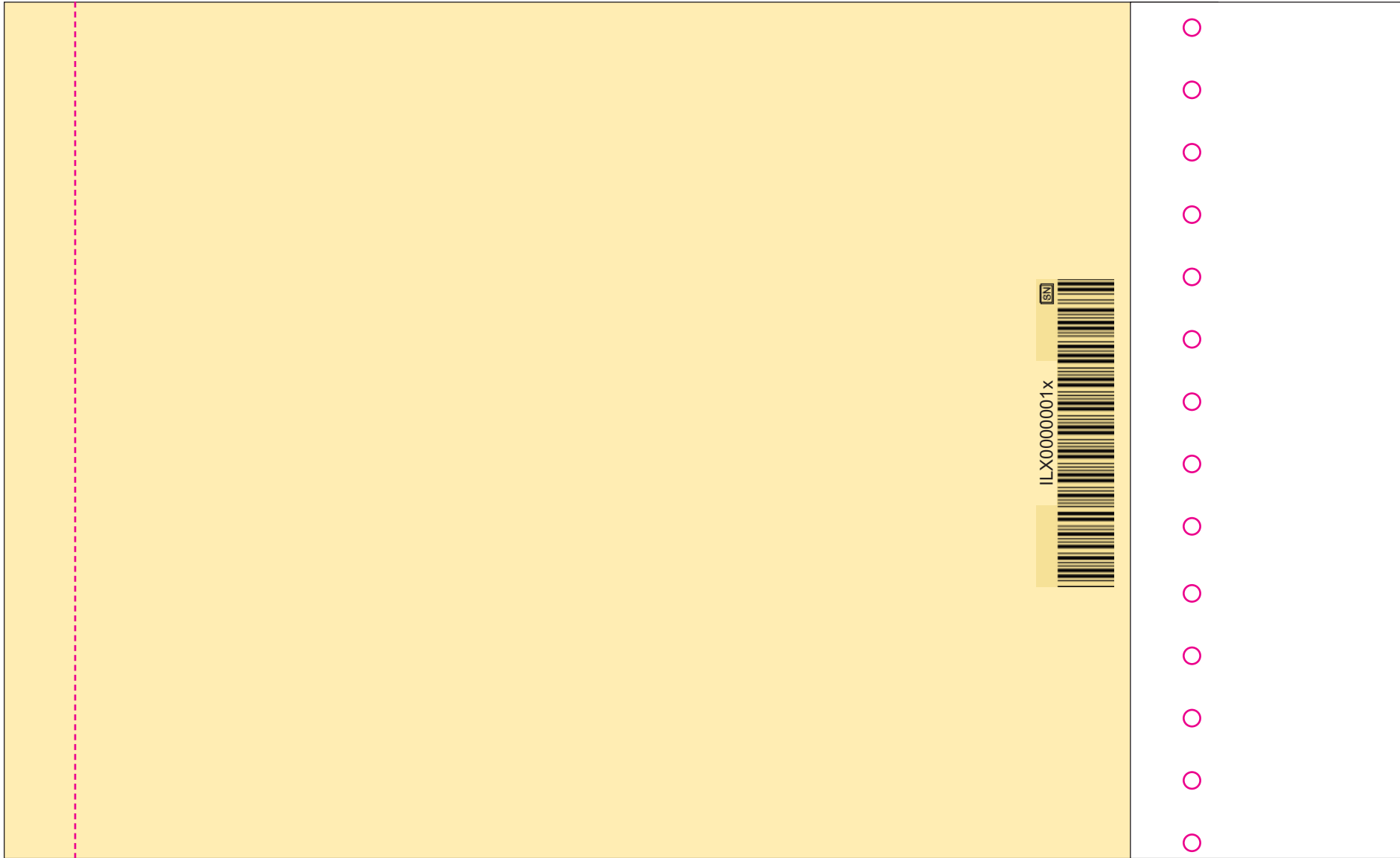
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Back of Part 4 and 5



Total Form
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