


To: Hospitals, Birthing Centers, Health Departments, and Physician Offices

From: Scott J. Zimmerman, DrPH, MPH, (HCLD (ABB), Director 

Date: April 10, 2016

Re: Change in Newborn Screening Filter Form DHHS #3105

The Newborn Screening (NBS) Unit of the North Carolina State Laboratory of Public Health (NCSLPH) is pleased to announce major revisions to the Newborn Screening Filter Form, DHHS #3105 (see example on reverse side). These changes correspond to updates with the Hearing Link module implemented in April 2015.

Please note these changes and additions to the demographic fields found on the front of the form:

1. **SPECIMEN TYPE:** there are now 4 choices for the type of specimen being submitted.
 - **FIRST TEST** is for the initial specimen collected on the infant. For an infant initially screened in another state, select **FIRST TEST**.
 - **REPEAT UNSAT** requires recollection of a specimen due to an unsatisfactory initial specimen
 - **REPEAT OTHER** is a recollection of a specimen from the infant, for reason other than a previous unsatisfactory initial specimen.
 - **KNOWN PKU** is a specimen collected from a patient with a previously confirmed diagnosis of phenylketonuria (PKU) and is used for monitoring purposes.
2. **ADDITION of CURRENT WEIGHT IN GRAMS** (an updated field): Enter the weight of the infant at the time of specimen collection.
3. **LATEST RBC TRANSFUSION DATE** (an updated field): Enter the latest, not first, RBC transfusion date and time.
4. **GESTATIONAL AGE** (a new field): Enter the gestational age of the infant in this field.



5. **MECONIUM ILEUS** (a new field): Meconium ileus is an indicator for Cystic Fibrosis.
6. **NICU** (a new field): Mark this field if the infant is in the NICU at the time of specimen collection.

Furthermore, there have been updates to the INSTRUCTIONS on the reverse of the form. Note that the NCSLPH advises that *newborn screening specimens are to be shipped within 24 hours of collection, and never held or batched.* In addition, NCSLPH recommends using overnight delivery methods for rapid transport of specimens to NCSLPH for testing.

NCSLPH encourages all persons involved in any way with Newborn Screening to refer to the following national resources on proper submission of specimens:

- American College of Medical Genetics' recommendations on proper submission (<https://www.acmg.net>)
- Clinical Laboratory Standards Institute document NBS01-A6, Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard-Sixth Edition (www.clsi.org)

In addition, these changes will be reflected in the Newborn Screening online training available which can be found at <http://slph.adobeconnect.com/newborn/>.

For questions concerning the new filter forms, contact the NCSLPH Newborn Screening Program at (919) 733-3937. If you have questions concerning these changes as they relate to data entry in the North Carolina Hearing Link Program, contact Marcia Fort, AuD., at (919) 707-5635.





Public Health
HEALTH AND HUMAN SERVICES

DANIEL STALEY
Director, Division of Public Health

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Laboratory Director

**DO NOT FOLD - INSTRUCTIONS ON BACK
MAIL USING OVERNIGHT DELIVERY METHODS**

NC STATE DIVISION OF PUBLIC HEALTH
LABORATORY SERVICES
4312 DISTRICT DRIVE, RALEIGH, NC 27607-3025
919 733 7834 T | 919 733 8695 F

NEWBORN'S MEDICAL RECORD # _____

040752401

NEWBORN'S LAST NAME _____ FIRST NAME _____ MULTIPLE BIRTHS: (of multiple A, B, or C, etc.) _____

NEWBORN'S BIRTHDATE: MO DAY YEAR _____ BIRTHTIME: 24 HR CLOCK _____ RACE: _____ SEX: _____ TYPE OF FEEDING: _____ BIRTHWEIGHT IN OZ/AMS _____

COLLECTION DATE: MO DAY YEAR _____ COLLECTION TIME: 24 HR CLOCK _____ 1. White 2. Black 3. Am. Ind. 4. Asian 5. Native Hawaiian/Other Pacific Is. 6. Unknown 1. Male 2. Female 3. Ambiguous 1. Breast 2. Soy 3. Non-Soy 4. Formula 5. Parenteral DESTINATION/AGE CURRENT WEIGHT IN OZ/AMS _____

MOTHER'S LAST NAME _____ FIRST NAME _____ HEMING OR LATRO ORIGIN: 1. Yes 2. No 3. Unknown LATEST RBC TRANSFUSION DATE: MO DAY YEAR _____ TRANSFUSION TIME: 24 HR _____ NICU Y N MOTHER'S MAIDEN NAME _____ MOTHER'S PHONE: _____

MOTHER'S MAILING ADDRESS _____ AREA CODE _____ CITY _____ ST _____ ZIP _____ COUNTY OF RESIDENCE / COUNTY CODE _____

HOSPITAL/SPECIMEN SUBMITTER _____ FED. TAX ID _____

PHYSICIAN / PRACTICE NAME _____ FED. TAX ID _____

COLLECTOR'S INITIALS, PRINT LEGIBLY: _____

VERIFIER'S INITIALS, PRINT LEGIBLY: _____

HEARING SCREENING

RIGHT EAR SCREENER ID _____ MO DAY YEAR _____

Type of Screen: 1. PASS 2. REFER 3. Ongoing 4. TEAR

NOT SCREENED DUE TO: 1. Deceased 2. Transferred 3. Other

LEFT EAR SCREENER ID _____ MO DAY YEAR _____

Type of Screen: 1. PASS 2. REFER 3. Ongoing 4. TEAR

NOT SCREENED DUE TO: 1. Deceased 2. Transferred 3. Other

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