



Michigan Newborn Screening

Completing the Newborn Screening Card

The specimen submitter is legally responsible for the accuracy and completeness of the information on the newborn screening card. The information is entered into the database exactly as it appears on the card, therefore legibility is critical. Press firmly using a black pen and record the following information in the spaces provided:

INFANT INFORMATION:

- ✓ **INFANT'S NAME:** Record last name followed by first name. If no first name is available at the time of specimen collection, the last name followed by "boy" or "girl" should be used. For single mothers, use the last name of mother or last name specified by mother. DO NOT LEAVE BLANK.
- ✓ **GENDER:** Completely shade in the appropriate oval to designate newborn's gender as male or female.
- ✓ **BIRTH DATE:** Use a six-digit number (mm/dd/yy) for date of birth. For example, a birth on January 4, 2012 would be recorded as 010412.
- ✓ **BIRTH TIME:** Record time of birth in military time. For example, a birth at 4:30 p.m. would be recorded as 1630. Note: This information is only required on the "blue" first sample card. For help with time conversions see [Appendix 15](#)
- ✓ **BIRTH WEIGHT, GRAMS:** Record the birth weight in grams in the boxes provided. Do not use pounds and ounces. Note: This information is only required on the "blue" first sample card. For help with weight conversions see [Appendix 16](#)
- ✓ **CURRENT WEIGHT, GRAMS:** Record the current weight in grams in the boxes provided. Do not use pounds and ounces. Note: This information is only required on the "pink" repeat sample card. For help with weight conversions see [Appendix 16](#)
- ✓ **GESTATIONAL WEEKS:** Record weeks of gestation at time of birth. Note: This information is only required on the "blue" first sample card.
- ✓ **SINGLE BIRTH:** Completely shade in oval for single birth.
- ✓ **MULTIPLE BIRTH ORDER:** Completely shade in oval to record birth order by "A", "B", "C" etc. for twins, triplets, etc.
- ✓ **ANTIBIOTICS:** For the 24-36 hour specimen, check "antibiotics" if the newborn is currently receiving antibiotics or the mother was receiving ongoing antibiotics at the time of birth. Do not check antibiotics if the mother received one dose prior to a cesarean section. For the 30-day specimen, do not check antibiotics if the newborn received antibiotics in the past and is not currently receiving them.

- ✓ **SPECIMEN DATE:** Use a six-digit number (mm/dd/yy) representing the date on which the specimen was obtained.
- ✓ **COLLECTION TIME:** Record time of specimen collection in military time. For help with time conversions see [Appendix 15](#)
- ✓ **COLLECTED BY:** Record initials or employee hospital identification number of person collecting the specimen.
- ✓ **NICU/SPECIAL CARE:** Indicate if the newborn was in the NICU or special care nursery (SP Care) at the time the specimen was collected. If neither, completely shade in the oval next to “no”.
- ✓ **RBC TRANSFUSION:** Completely shade in oval “no” or “yes” to indicate whether the newborn was ever transfused with red blood cells **prior** to specimen collection. If yes, give date (mm/dd/yy) and the start time (military) of the **most recent** transfusion. For example, if the transfusion started on October 13, 2010 at 11:20 p.m., enter 101310 2320.
- ✓ **MEDICAL RECORD NUMBER BABY:** Record the birth hospital's identification or medical record number.
- ✓ **ANY TPN FEEDING:** Completely shade in oval “yes” if the newborn is receiving total parenteral nutrition (TPN) at the time the specimen is obtained -OR- received TPN within 24 hrs of specimen collection.
- ✓ **ANCESTRY:** Completely shade in oval for Hispanic or Non-Hispanic. Ancestry should be filled in first and, in addition, one of the six boxes for race should be filled in.
- ✓ **RACE:** Completely shade in the oval for one of the six racial categories after the designation of Hispanic or non-Hispanic has been selected. If the newborn has a parent in one racial category and the other parent in a different racial category, fill in the mixed race oval. It is very important to fill in either the Hispanic or non-Hispanic box and in addition fill in one of the six boxes for race.

Example 1: One parent who identifies as Hispanic and both parents are Black, the card should be marked Hispanic and Black.

Example 2: One parent is Black and the other is White and one parent identifies as Hispanic, the card should be marked Hispanic and Multi-Racial.

Example 3: One parent is Black and one parent is White and neither parent identifies as Hispanic, the card should be marked non-Hispanic and Multi-Racial.
- ✓ **TYPE OF COLLECTION:** The preferred collection method is by heel stick with a single drop of blood applied directly to each circle on the filter paper. Check both “heel” *and* “capillary” if the blood was collected from the heel using a capillary tube. Note that the use of a capillary tube can result in layered, serum, clotted and damaged specimens. If the heel was not used, indicate the alternate collection method.
- ✓ **OTHER FEEDING:** Check all that apply. For instance, if a mother is both breast and bottle feeding, mark both and indicate the type of formula.

MOTHER INFORMATION:

- ✓ **MOTHER'S NAME:** Record last name followed by first name. If the newborn is going to be released at birth to adoptive or foster parents, provide contact information of adoptive or foster mother. Please note in black ink above the mother's name that contact information is for adoptive or foster mother. Do not place sticky notes on the card or use red ink. Neither will be recorded when the card is scanned into the system. If contact information on new parents, foster parents, or the adoption agency is not on the card, we will not be able to contact the family if necessary. We would like to avoid calling the birth mother if she is no longer responsible for the care of the newborn.
- ✓ **MOTHER'S ADDRESS:** Record mother's current street address, followed by city, state and zip code. Information about the mother is needed to locate newborns in need of clinical evaluation or retesting.
- ✓ **MOTHER'S PHONE:** Record mother's area code and home telephone number.
- ✓ **MEDICAL RECORD NUMBER-MOTHER:** Record the hospital identification or medical record number. Note: This information is only required on the "blue" first sample card.
- ✓ **BIRTH DATE:** Record the mother's date of birth (mm/dd/yy).
- ✓ **HEPATITIS B SURFACE ANTIGEN (HBsAg):** Provide date of test (mm/dd/yy) and completely shade in the appropriate oval to indicate a positive or negative result. If there is no HBsAg test result in the mother's record, the test should be done immediately. Positive HBsAg results should be reported to the MDCH Hepatitis B program at (517) 335 9443 or fineisp@michigan.gov. This important information helps assure that infants at risk receive the proper immunizations WITHIN 12 HOURS OF BIRTH. Note: This information is only required on the "blue" first sample card.

PROVIDER INFORMATION:

- ✓ **PROVIDER'S NAME:** Record last name, followed by first name, of the health care provider to be notified of an unsatisfactory or positive newborn screening test. If the mother does not offer a primary care provider's name, the physician in charge of the newborn nursery should be listed on the NBS card. The physician should arrange for all retesting through the hospital's outpatient laboratory. If the newborn is expected to be in the NICU for at least a week, list a staff neonatologist as the physician and write the NICU phone and fax numbers on the NBS card. If discharge is expected within a week, write the name and clinic phone and fax number of the provider who will be taking care of the newborn after discharge.
- ✓ **PROVIDER'S PHONE:** Indicate the primary care provider's area code followed by the telephone number. It is very important to provide a complete and correct number. This information is used to contact the health care provider with positive test results and follow-up information. If the hospital newborn nursery chooses to follow-up positive results directly, provide the name and telephone number of the staff person designated to contact the family. This option is preferred for newborns without a designated primary care provider.
- ✓ **PROVIDER'S FAX:** Indicate the primary care provider's area code followed by fax number. The fax number is needed to forward to the physician screening results that require further follow-up.

SUBMITTER INFORMATION:

- ✓ **SUBMITTER NAME:** Record the name of the submitter (this should be the birth hospital or midwife on all initial newborn screens). If abbreviation of the hospital's name is necessary, use some letters from each word in the hospital's name. For example, the abbreviation for St. Joseph Mercy Hospital would be St. Jos. Mrcy. It is acceptable to apply a pre-printed hospital label that includes the hospital name, address, phone number and the appropriate hospital code.
- ✓ **HOSPITAL CODE:** MDCH has assigned a 3-digit hospital code for each hospital that must be recorded in the boxes provided. The 3-digit code should be listed before the two preprinted zeros. For regular nurseries, a "0" should be added to the last box (after the two preprinted zeros). For the NICU, a "1" should be added to the last box. For the special care nursery, a "2" should be added to the last box.
- ✓ **SUBMITTER ADDRESS:** Record the submitter's street address followed by the city, state and zip code.
- ✓ **SUBMITTER PHONE:** Record submitter's area code and phone number.
- ✓ **BIRTH HOSPITAL:** Record name of the birth hospital here only if different from the submitter. It is extremely important to fill out the screening card completely and accurately.

Recording the NBS Card Number

Newborn screening protocol should include instructions on how to record the NBS card (kit) number on the electronic birth certificate (EBC). This number is located on the lower right hand corner of the card (see below) and is referred to as the “metabolic number” on the EBC.

BABY	LAST NAME										FIRST NAME										GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE		
	BIRTH DATE				BIRTH TIME (Military)				BIRTH WT. (gms)				WKS GESTATION				SINGLE BIRTH <input type="radio"/> MULTIPLE BIRTH <input type="radio"/>		BIRTH ORDER A B C D		ANTIBIOTICS? <input type="radio"/> NO <input type="radio"/> YES		
	SPECIMEN DATE				COLLECTION TIME (Military)				Collected By: (initials)				NICU or SPECIAL CARE? <input type="radio"/> NO <input type="radio"/> YES		ANY RBC TRANSFUSION? <input type="radio"/> NO <input type="radio"/> YES		TRANSFUSION DATE				TRANS. START TIME (Military)		
	MEDICAL RECORD #										ANY TRN FEEDING? <input type="radio"/> NO <input type="radio"/> YES		<input type="radio"/> HISPANIC <input type="radio"/> NON-HISPANIC		<input type="radio"/> WHITE <input type="radio"/> BLACK		<input type="radio"/> AMERICAN INDIAN <input type="radio"/> ASIAN/PACIFIC ISLAND.		<input type="radio"/> ARAB DESCENT <input type="radio"/> MULTI-RACIAL				
TYPE of COLLECTION: <input type="radio"/> Heel Stick <input type="radio"/> Capillary (heparin, EDTA, other) <input type="radio"/> Line Draw (central, other)										Type of Flush (heparin, saline, other)										OTHER FEEDING: <input type="radio"/> BREAST <input type="radio"/> MILK-BASE <input type="radio"/> SOY <input type="radio"/> NONE			
MOTHER	LAST NAME										FIRST NAME												
	ADDRESS										PHONE												
	CITY										STATE		ZIP										
MEDICAL RECORD #										BIRTH DATE				HEPATITIS B SURFACE ANTIGEN (HBsAg) TEST DATE				RESULT <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE					
PROVIDER	LAST NAME										FIRST NAME												
	PHONE										FAX												
SUBMITTER	SUBMITTER NAME										HOSPITAL CODE (if applicable)										00		
	ADDRESS										PHONE												
	CITY										STATE		ZIP										
BIRTH HOSPITAL (if different from submitter)										Lot 100535 / xxxxxx										EXPIRES: yyyy-mm			

MDCH USE ONLY

MI Dept. of Comm. Hlth.
 By Authority of Act 568
 P.A. MCLA 333.5431



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FIRST SAMPLE

MDCH USE ONLY