

5.8 (old 3.13.8) Instructions for Collection, Handling, and Mailing of Blood Specimens for Confirmatory Testing for Hemoglobinopathies

BASIC BLOOD SPECIMEN COLLECTION:

All blood is to be collected in EDTA (lavender top) tube and immediately inverted several times to ensure the blood is well mixed with the anticoagulant.

Tubes **MUST** be labeled with **PATIENT NAME** and **COLLECTION DATE**.

SPECIMEN REQUIREMENTS

NEWBORN: DRAW 3CC VIA VENIPUNCTURE, LAV. EDTA-WHOLE, BLOOD, MIN. 1.5CC

INFANT/CHILD 6 MONTHS OR OLDER:
DRAW 5CC, LAV. EDTA-WHOLE BLOOD, MIN. 2.5CC

ADULT: DRAW 5CC, LAV. EDTA-WHOLE BLOOD, MIN. 2.5CC

FOR LABORATORY USE ONLY: BLOOD PACKING AND MAILING

1. Insert the specimen tubes into a Biohazard plastic bag with absorbent material (paper towel) and seal the bag.
2. COMPLETE THE INTAKE FORM and INSERT IT INTO THE OUTSIDE POUCH OF THE PLASTIC BIOHAZARD BAG.
3. Insert the sealed plastic bag into the enclosed mailing case. Close the mailing case.
4. Place the mailing case in the Golden State Overnight envelope with attached pre-printed shipping label.
**Send to: Hemoglobin Reference Laboratory
Children's Hospital & Research Center at Oakland
attention: Mahin Azimi
747 52nd Street, Oakland, CA 94609
Telephone: (510) 450-7688**
5. Take to GSO package pick-up area in the hospital or lab. If GSO does not pick up at your hospital or lab, call Golden State Overnight Service at 800-322-5555 to arrange for same day pickup, if after 4pm pick –up will occur the next day.
6. Please notify the Newborn Screening Area Service Center (ASC) listed on the reverse page when the specimen is collected.

Call your Newborn Screening Area Service Center if you have any questions about specimen collection or mailing.

The ASC newborn screening follow-up coordinator will receive the confirmatory hemoglobin test results and notify the referring physician of the results by phone and mail.

INTAKE FORM

NEWBORN SCREENING HEMOGLOBINOPATHY REFERENCE LABORATORY
Children's Hospital & Research Center at Oakland, P.O.Box 3330, Oakland, CA 94609-9925

NEWBORN'S NAME: _____ AKA (IF KNOWN): _____
(LAST) , (FIRST) (LAST) , (FIRST)

NB SCREEN Hb PATTERN: _____ INITIAL ACC#: _____ - _____ - _____ / _____ - _____ - _____

AREA SERVICE CENTER (ASC) CODE: _____ ASC PHONE NUMBER: _____

ASC NAME: _____

SENDER: NAME _____

PHONE NUMBER _____

NEWBORN'S PHYSICIAN: NAME _____

PHONE NUMBER _____

NAME (Last, First)	TRANS- FUSED? (Y/N) Date & type	BIRTH DATE	SEX	RELATIONSHIP TO PATIENT	DATE COLLECTED	ETHNICITY/RACE (Indicate all)

LAB: Please notify the ASC listed above when the specimens have been collected and sent to the Hemoglobinopathy Reference Laboratory.

Date ASC Notified: _____

THE ASC NEWBORN SCREENING FOLLOW-UP COORDINATOR WILL BE NOTIFIED ABOUT THE RECALL HEMOGLOBINOPATHY TEST RESULTS.