

NBS COPY

CALIFORNIA NEWBORN SCREENING
TEST REQUEST FORM (TRF)
State of California -
Health and Human Services Agency
California Department of Public Health

FOR STATE USE ONLY

ADDRESSOGRAPH HERE

Series Indicator

Check Digits



SN

27 000 001 10

BABY'S INFORMATION PLEASE PRINT USING ALL CAPITAL LETTERS

BIRTH ORDER
IF MULTIPLE
A, B, C, etc.

B A B Y S L A S T N A M E
F I R S T N A M E
S T R E E T A D D R E S S A P T
C I T Y Z I P

MOTHER'S INFORMATION/LEGAL GUARDIAN INFORMATION

MOTHER'S BIRTH DATE

M O T H E R S L A S T N A M E M M D D Y Y
F I R S T N A M E M I S S N #
M A I D E N N A M E
M O M P H O N E A L T E R N A T E /
E M E R G E N C Y # P H O N E

THIS BABY IS A WARD OF THE COURT - CONTACT INFORMATION

N A M E P H O N E

NEWBORN'S PHYSICIAN INFORMATION

P H Y S I C I A N L A S T N A M E
F I R S T N A M E
S T R E E T A D D R E S S S U I T E
C I T Y Z I P
P H Y P H O N E L I C # O R N P I

RACE/ETHNICITY: FILL ALL THAT APPLY

WHITE CHINESE VIETNAMESE OTHER S.E. ASIAN MIDDLE EASTERN HAWAIIAN SAMOAN
 HISPANIC JAPANESE CAMBODIAN FILIPINO ASIAN-EAST INDIAN GUAMANIAN NATIVE AMERICAN
 BLACK KOREAN LAOTIAN (LAOS) OTHER (Specify):

PRIMARY LANGUAGE: (Fill only ONE circle)

ENGLISH SPANISH OTHER (Specify):

FACILITY/SUBMITTER DRAWING SPECIMEN

F A C I L I T Y N A M E H O S P I T A L /
S U B M I T T E R C O D E I N I T I A L S O F C O L L E C T O R

NEWBORN'S BIRTH DATE:

M M D D Y Y H O U R

DATE SPECIMEN COLLECTED:

M M D D Y Y H O U R

BIRTH WEIGHT:

GMS

ALL FEEDINGS SINCE BIRTH:
(Fill only ONE circle)

ONLY HUMAN MILK
 ONLY FORMULA
 HUMAN MILK & FORMULA

TYPE OF SPECIMEN:

HEELSTICK OTHER: (Specify)

SEX:

MALE FEMALE

REASON FOR TEST: (Fill only ONE circle)

INITIAL SPECIMEN
 REPEAT OF INADEQUATE OR EARLY (<12 HRS) INITIAL SPECIMEN
 OTHER REPEAT: (Specify)

GESTATIONAL AGE AT DELIVERY:

WEEKS

NPO AT TIME OF COLLECTION?

NO YES

IF COLLECTED AT <12 HRS OF AGE, REASON:

TO BE TRANSFUSED
 OTHER: (Specify)

NURSERY TYPE:

NICU
 REG. NURSERY/FCC/RI
 HOME BIRTH
 OTHER: (Specify)

NEWBORN ON TPN/HYPERAL OR AMINO ACIDS AT TIME OF COLLECTION?

NO YES

RBC TRANSFUSION BEFORE COLLECTION:

NO YES - if YES, date/time transfusion completed
M M D D Y Y H O U R

MEDICAL RECORD/EHR#

HOSPITAL ORDER #

PLEASE SEE PRIVACY NOTIFICATION WITHIN
To reorder, request form NBS-TRF from the Genetic Disease Screening Program,
Newborn Screening Branch (510) 412-1542 (CDPH - 4409 - (05-11)) NBS-1 (B)

Ahlstrom 226 LOT 0120201 / XXXXXX



Important Changes to Collecting the Newborn Screening Blood Test

Using the New 27 Million Series TRF Form

Future use for electronic record transfer. Leave blank for now.

DO NOT USE AN EXPIRED FORM.

Check the expiration date listed next to the hourglass icon.

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TEST REQUEST FORM (TRF)
State of California -
Health and Human Services Agency
California Department of Public Health

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SN

27 000 001 10

Check Digits

BABY'S INFORMATION PLEASE PRINT USING ALL CAPITAL LETTERS

B	A	B	Y	'	S		L	A	S	T		N	A	M	E				
F	I	R	S	T			N	A	M	E									
S	T	R	E	E	T		A	D	D	R	E	S			A	P	T		
C	I	T	Y												Z	I	P		

BIRTH ORDER
IF MULTIPLE
A, B, C, etc.

MOTHER'S INFORMATION/LEGAL GUARDIAN INFORMATION

MOTHER'S BIRTH DATE

M	O	T	H	E	R	'	S		L	A	S	T		N	A	M	E		
M	M	D	D	Y	Y														
F	I	R	S	T			N	A	M	E					M	I	S	S	N
M	A	I	D	E	N		N	A	M	E									
M	O	M					P	H	O	N	E				A	L	T	E	R

MOTHER'S SSN: LAST 4 DIGITS

THIS BABY IS A WARD OF THE COURT - CONTACT INFORMATION

N	A	M	E												P	H	O	N	E
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NEWBORN'S PHYSICIAN INFORMATION

P	H	Y	S	I	C	I	A	N		L	A	S	T		N	A	M	E	
F	I	R	S	T															
S	T	R	E	E	T		A	D	D	R	E	S			S	U	I	T	E
C	I	T	Y												Z	I	P		
P	H	Y					P	H	O	N	E		L	I	C	#		O	R

RACE/ETHNICITY: FILL ALL THAT APPLY

WHITE CHINESE VIETNAMESE OTHER S.E. ASIAN MIDDLE EASTERN HAWAIIAN SAMOAN
 HISPANIC JAPANESE CAMBODIAN FILIPINO ASIAN-EAST INDIAN GUAMANIAN NATIVE AMERICAN
 BLACK KOREAN LAOTIAN (LAOS) OTHER (Specify): _____

PRIMARY LANGUAGE: (Fill only ONE circle)

ENGLISH SPANISH OTHER (Specify): _____

FACILITY/SUBMITTER DRAWING SPECIMEN

F	A	C	I	L	I	T	Y		N	A	M	E			H	O	S	P	I	T	A	L	/	S	U	B	M	I	T	T	E	R	C	O	D	E			I	N	I	T	I	A	L	S	O	F	C	O	L	L	E	C	T	O	R
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NEWBORN'S BIRTH DATE:

M	M	D	D	Y	Y			H	O	U	R								
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DATE SPECIMEN COLLECTED:

M	M	D	D	Y	Y			H	O	U	R								
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BIRTH WEIGHT:

_____ GMS

ALL FEEDINGS SINCE BIRTH:

(Fill only ONE circle)
 ONLY HUMAN MILK
 ONLY FORMULA
 HUMAN MILK & FORMULA

TYPE OF SPECIMEN:

HEELSTICK OTHER: (Specify) _____

SEX:

MALE FEMALE

REASON FOR TEST: (Fill only ONE circle)

INITIAL SPECIMEN
 REPEAT OF INADEQUATE OR EARLY (<12 HRS) INITIAL SPECIMEN
 OTHER REPEAT: (Specify) _____

GESTATIONAL AGE AT DELIVERY:

_____ WEEKS

NPO AT TIME OF COLLECTION?

NO YES

IF COLLECTED AT <12 HRS OF AGE, REASON:

TO BE TRANSFUSED
 OTHER: (Specify) _____

NURSERY TYPE:

NICU
 REG. NURSERY/FCC/RI
 HOME BIRTH
 OTHER: (Specify) _____

NEWBORN ON TPN/HYPERAL OR AMINO ACIDS AT TIME OF COLLECTION?

NO YES

RBC TRANSFUSION BEFORE COLLECTION:

NO YES - if YES, date/time transfusion completed

MEDICAL RECORD/EHR#

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HOSPITAL ORDER #

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Changes And New Fields

Collect only the last four digit or use 9999 if there is no number.

An additional number to contact parent, guardian or emergency contact.

If baby is a ward of the court, check box.

- If other legal guardian, social worker, or caretaker is available, enter in name and phone number.
- Enter mother's information as well.

This field has moved.

See page 4 for instructions.

- Gestational Age
- NPO at Time of Collection
- Home Birth

New!
Six blood spots required for a complete blood specimen.

27 000 001 10

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
 NEWBORN SCREENING

LOT]0120201 / XXXXXXXX YYYYY-MM Revision Date: 05/11
 ID 226 (Anstrom)

CDPH USE ONLY

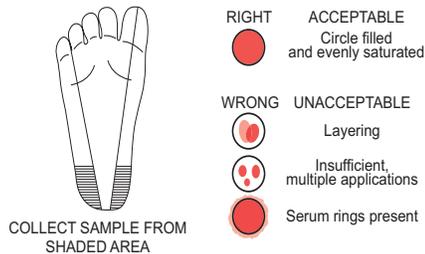
27 000 001 10

DO NOT DETACH

INSTRUCTIONS FOR COLLECTING ADEQUATE BLOOD SPECIMENS

Puncture site is indicated by shaded areas on heel. Do not collect from side or back of foot.

***NO COURIER PLASTIC BAGS**



NOTE:

*Do not use capillary tubes for collection of blood spot specimen.
 Do not collect blood from antecubital space or dorsal hand vein.
 Do not handle blood collection area of specimen collection card prior to, during, or following sampling.*

1. Position infant's foot to increase blood flow. Warming of the heel is optional.
2. Clean skin with alcohol and either air-dry or wipe dry with sterile gauze.
3. Puncture heel with sterile disposable lancet, using a firm, quick stab. If using an automated lancet device, place it firmly against the heel prior to device activation.
4. Allow a large drop of blood to accumulate and wipe away with sterile gauze.
5. Allow a second large drop of blood to accumulate. Apply gentle pressure to heel and ease intermittently so blood flows freely.
6. Apply the blood drop to one side of the specimen collection paper until the circle is filled COMPLETELY when viewed from both sides. Do not press collection paper against puncture site. Allow blood to fill circle by natural flow. **Do not apply blood to both sides of the paper.**
7. Fill the first circle completely before moving on to the next circle. Repeat procedure for each circle.
8. Allow blood spots to air-dry at room temperature for at least three hours. Keep away from direct light (sun or lamp) and heat.
9. Do not close specimen collection form while blood spots are still wet. Do not allow wet specimens to come in contact with each other.
10. DO NOT PUT SPECIMEN IN PLASTIC BAG.

ADDITIONAL INSTRUCTIONS ARE CONTAINED IN "BLOOD COLLECTION ON FILTER PAPER FOR NEWBORN SCREENING PROGRAMS", 5th EDITION (CLSI DOCUMENT LA4-A5)

PRINT ONLY, USE ALL CAPITAL LETTERS, USE BLACK OR BLUE INK ONLY.

Six spots are needed for increased number of disorders added to the California screening panel.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING



DO NOT WRITE IN THIS AREA
DO NOT HANDLE FILTER PAPER

THIS AREA MAY BE USED TO ADHERE A STICKER
CONTAINING THE INFANT'S FACILITY INFORMATION

Revision Date: 05/11

Read carefully:
New instructions for
items 2, 3, 11, and 14.

INSTRUCTIONS FOR COMPLETION OF FORM

PLEASE PRINT AND USE BLUE OR BLACK BALL POINT PEN

- NEWBORN'S NAME:** Name as entered on birth certificate, last name first. If multiple birth, indicate A, B, C, etc.
- MOTHER'S INFORMATION:** Name as entered on birth certificate, last name first. Please also include mother's maiden name and last 4 digits of social security number. **If mother does not have a social security number, enter 9999.**
- THIS BABY IS A WARD OF THE COURT – CONTACT INFORMATION:** Answer YES if newborn is a ward of the court and provide contact information for person responsible for baby's care at time of collection.
- NEWBORN'S PHYSICIAN INFORMATION:** Obtain from mother the name of the physician responsible for continuing care of the newborn after discharge.
- NEWBORN'S PHYSICIAN'S LICENSE NUMBER OR NPI NUMBER:** Enter the physician's California license number or national provider identification number.
- RACE/ETHNICITY:** As entered for both parents on birth certificate. These data are required by Government Code 8310.05. Check ALL that apply.
- PRIMARY LANGUAGE:** Please indicate primary language spoken; this helps determine if an interpreter is needed.
- FACILITY DRAWING SPECIMEN:** Name and code number must be entered to ensure correct reporting of results.
- NEWBORN'S BIRTH DATE (AND TIME):** As entered on the birth certificate. All time is to be entered by the 24 hour clock, e.g., 8:30 a.m. is 0830; 9:01 p.m. is 2101.
- BIRTH WEIGHT:** In grams, as entered on birth certificate.
- GESTATIONAL AGE:** Enter gestational age at time of birth in weeks.
- NURSERY TYPE:** Check NICU, Regular Nursery, which includes Family Centered Care (FCC) or Rooming In (RI), **Home Birth**, or other.
- ALL FEEDING SINCE BIRTH:** Include all feeding from birth to collection. Human milk includes breastfeeding, mother's own expressed milk and banked human milk. If newborn has had neither human milk, nor formula leave this section blank.
- NPO AT TIME OF COLLECTION?:** Answer YES if newborn is NPO (i.e., is taking nothing by mouth) at time of specimen collection.
- NEWBORN ON TPN/HYPERAL or AMINO ACIDS AT TIME OF COLLECTION?:** Answer YES if newborn is being given TPN (total parenteral nutrition, aka hyperalimentation) or amino acids at time of specimen collection.
- DATE SPECIMEN COLLECTED:** Date and hour of specimen collection. This refers to the time the specimen is collected from the newborn.
- TYPE OF SPECIMEN:** Please check only one box. If "OTHER: type of specimen is checked, please specify the type of specimen.
- IF COLLECTED AT <12 HRS OF AGE, REASON?:** If this specimen is being collected prior to the newborn being 12 hours of age, indicate why.
- RBC TRANSFUSION BEFORE COLLECTION:** Please indicate whether the newborn was transfused with RED BLOOD CELLS and the date and time the last transfusion ended prior to specimen collection. DO list intrauterine transfusions. DO NOT list fresh frozen plasma, albumin, platelets, or cryoprecipitate as transfusion. DO NOT list transfusions that occurred after the specimen was collected.
- MEDICAL RECORD NUMBER:** Enter number used in medical records department of facility collecting specimen.
- INITIALS OF COLLECTOR:** Enter initials of person drawing the specimen.
- DISTRIBUTION:** Original **MUST** remain attached to specimen. Facility drawing the specimen should retain and file the yellow copy in the newborn's chart. The pink copy should be given to the newborn's parent(s) with instructions to give to the newborn's physician.

New Instruction # 2

New Instruction # 3

- Such as the medical social worker

New Instruction # 11

- Add gestational age on every screen

New Field

- Check if Home Birth
- For others please list: Pediatric Unit, Outpatient Lab, etc.

New Instruction # 14

- If NPO at collection, check Yes or No on All Infants.

15. Check Yes or No on ALL infants.

PLEASE SEE PRIVACY NOTIFICATION WITHIN