

Filling Our Demographics on Montana Newborn Screening Blood Spot Collection Forms

MONTANA DPHHS NEWBORN SCREENING
Public Health Laboratory, P.O. Box 4369, Helena, MT 59604-4369
CLIA ID # 27D0632531
REF: Rev AB
7128118
LOT: W171
Public Health Laboratory, (800) 821-7224
2021-11-30
WD

MONTANA DPHHS NEWBORN SCREENING Public Health Laboratory P.O. Box 4369, Helena, MT 59604-4369		SN		363994
Baby's Last Name	BABY'S LAST NAME			
Baby's First Name	BABY'S FIRST NAME			
Baby's ID Number	MEDICAL RECORD NO.			
Mother's Last Name	BIRTH MOTHER'S LAST NAME			
Mother's First Name	BIRTH MOTHER'S FIRST NAME			
Baby's Provider	LAST NAME, FIRST NAME			
Medicaid ID Number				
Provider NPI #				
Submitting Facility:				

**WE WILL APPLY A STICKER HERE
WITH YOUR FACILITY INFORMATION**

PLEASE LEAVE BLANK

RACE OF BABY (Check all that apply)		SPECIMEN					
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Native Amer.	<input type="checkbox"/> Asian	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown	<input type="checkbox"/> 1st	<input type="checkbox"/> Repeat
ETHNICITY OF BABY (Check only one)		BIRTH DATE AND TIME					
<input type="checkbox"/> Non-Hispanic		<input type="checkbox"/> Hispanic		<input type="checkbox"/> Unknown		TIME (MILITARY)	
M O		D A Y		Y E A R		24-HR CLOCK	
SPECIMEN COLLECTION DATE AND TIME		TIME (MILITARY)					
M O		D A Y		Y E A R		24-HR CLOCK	
<input type="checkbox"/> SINGLE BIRTH		BIRTH WEIGHT (grams)					
<input type="checkbox"/> IF MULTIPLE		<input type="checkbox"/> A		<input type="checkbox"/> B		<input type="checkbox"/> —	
G R A M S							
HAS THE BABY RECEIVED A RBC TRANSFUSION? <input type="checkbox"/> Y <input type="checkbox"/> N							
DATE OF TRANSFUSION							
OTHER CONSIDERATIONS <input type="checkbox"/> Adopted							
IS THE BABY IN THE NICU? <input type="checkbox"/> Y <input type="checkbox"/> N							
NICU INFANT INFORMATION				GESTATIONAL AGE			
FEEDING METHOD				(weeks)			
<input type="checkbox"/> TPN <input type="checkbox"/> Breast <input type="checkbox"/> Formula, Soy				<input type="checkbox"/> Formula, Lactose			
IS MOTHER OR INFANT ON STEROIDS? <input type="checkbox"/> Y <input type="checkbox"/> N				IS MOTHER OR INFANT ON ANTIBIOTICS? <input type="checkbox"/> Y <input type="checkbox"/> N			

Baby's Last Name: If the last name has changed since the baby was born, please enter it here. We are required to enter what is on the requisition, not what is on the patient manifest.

Baby's First Name: If the newborn does not yet have a name, we will use the sex and mother's first name (e.g. BoyEmily or GirlElizabeth). In the case of multiples, we will use birth order, sex, and mother's first name (e.g. ABoyEmily or BGirlElizabeth). This is to avoid confusion if we have a baby with the same sex, same date of birth, and same last name.

Baby's ID Number: This should be a unique number assigned to the baby, for example a medical record number. This unique number helps to avoid having multiple records in our laboratory information system.

Gender: Please check male or female. In some cases, it is difficult to discern by the newborn's first name.

Mother's Last Name: This should be the birth mother's last name, regardless if this is a surrogacy or adoption situation. If the birth mother's name is not known, please indicate that on the requisition.

Mother's First Name: This should be the birth mother's first name, regardless if this is a surrogacy or adoption situation. If the birth mother's name is not known, please indicate that on the requisition.

Baby's Provider: Please provide the name of the pediatrician who attended or who will take over the baby's care after discharge. Please enter the last name AND the first name. **This information is required for NBS follow-up, if needed.**

Medicaid ID Number: As applicable.

Provider NPI Number: If known. This information ensures that we select the correct provider for the baby's care.

Race of Baby: Check all that apply, if known. If nothing indicated, our laboratory information system will default to unknown.

Ethnicity of Baby: Check only one, if known. If nothing indicated, our laboratory information system will default to unknown.

Specimen: Please check first if this is the first screen drawn on the newborn. Please check repeat if this is a subsequent screen drawn on the newborn.

Birth Date and Time: Please enter the two-digit month, two-digit date, and four-digit year. The time should be on a 24-hour scale.

Collection Date and Time: Please enter the two-digit month, two-digit date, and four-digit year. The time should be on a 24-hour scale. This is essential information since Montana rule specifies timing of collection of samples.

Birth Order: If this is a single birth, please mark single. In case of multiples, please indicate the birth order for the newborn.

Birth Weight: Please enter the birth weight in grams. This is the **newborn's weight at birth**, not the weight at the time the sample was drawn.

If the baby has received a **blood transfusion**, please mark yes, and indicate the date. If nothing is marked, the answer will default to no.

Please indicate if the newborn is in the **NICU**. If nothing is marked, the answer will default to no.

NICU Newborn Information: This information is helpful to capture on all newborns, not just NICU newborns. **Please provide all information, since it might be used in screening result evaluation.**

Gestational Age: This is the week of gestation when the baby was born, not what would be the gestation at the time the sample was drawn.

Feeding Method: Please indicate the feeding method, if known, at the time of collection. **It is especially important to note Total Parenteral Nutrition (TPN) for screening result evaluation.**

Is Mother or Infant on Steroids? Antibiotics? Check yes or no. **Some medications can affect screening results.**