

North Dakota Newborn Screening Bloodspot Card

North Dakota

Expiration Date 2020-01-31

North Dakota Newborn Screening Program Form

<input type="checkbox"/> Initial Screen <input type="checkbox"/> Repeat Screen		Collection Date Year Month Day		Collection Time (24 hour clock)		Collector		Infant's Medical Record #	
Infant's Last Name				Infant's First Name					
Infant's Birth Date Year Month Day		Infant's Birth Time (24 hour clock)		Infant's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Infant's Street Address			
City		State		Zip Code		If multiple A,B ...etc		Gestational Age at Birth	
Current Weight (g)		Transfused Before Collection Any Blood Products <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Date of Last Transfusion Year Month Day		Feeding Method (Check all that apply) <input type="checkbox"/> Breast Milk <input type="checkbox"/> Formula <input type="checkbox"/> TPN <input type="checkbox"/> None of the above		<input type="checkbox"/> Check if infant is in NICU <input type="checkbox"/> Check if infant has Meconium Ileus	
Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Other Please Specify		Guardian's Last Name		Guardian's First Name		Guardian's Phone Number			
Guardian's Birth Date Year Month Day		Guardian's Gender <input type="checkbox"/> M <input type="checkbox"/> F		Birth Mother's Maiden Name					
Ordering Health Care Provider's Last Name		Ordering Health Care Provider's First Name		Ordering Health Care Provider's Phone Number					
Ordering Health Care Provider's NPI		Facility of Birth (Name, City, State)							
Primary Care Provider's Last Name		<input type="checkbox"/> Check if same as above		Primary Care Provider's First Name		Primary Care Provider's Phone Number			
Submitting Facility's Name		Submitting Facility's Street Address							
City		State		Zip Code					

DO NOT WRITE IN THIS SPACE

PLACE THE HL7 LABEL
WITHIN THIS BOX

DO NOT WRITE IN THIS SPACE

FOR SHL USE ONLY



DO NOT REMOVE THIS COVER FLAP. IT IS FOR THE PROTECTION OF THE SPECIMEN AND THE SPECIMEN HANDLERS.

PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY

AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN.

- 1) Do not touch sample area
- 2) Do not use if damaged

