

DHEC 1327, Newborn Screening Collection Form

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL  
BUREAU OF LABORATORIES

Newborn Screening (Instructions for Completing DHEC-1327) Revised 9/2004.

**PURPOSE**

Metabolic testing on newborns in South Carolina is a State Law. This form is used to provide identification and essential information and a means of submitting blood samples for newborn screening. Due to the makeup of this form and the information needed, it cannot be pre-addressed by the Bureau of Laboratories. It has to be filled out completely by the provider. NOTE: There is a space for two senders. Both senders will receive a copy of the results.

A completed form must be submitted with the circles on the filter paper filled with the newborn's blood. The instructions for specimen collection and handling of blood specimen are on the back of the form. Never place the form in plastic bags to submit to the laboratory. Plastic bags can cause false laboratory results. Always check expiration date of the filter paper. This information is on the filter paper. The laboratory will not accept blood on expired filter paper forms. Follow the general instructions for the patient and sender information. Further instructions are below.

**BABY'S LAST NAME:** Enter baby's legal last name

**BABY'S FIRST NAME:** Enter baby's legal first name

MOTHER'S LAST NAME: Enter mother's last name, adoption agency or lawyer's office (if considered baby's legal guardian).

MOTHER'S FIRST NAME: Enter mother's first name.

BABY'S ADDRESS: Enter baby's complete mailing address, city, state, county code, and zip code. (See back of the sender copy for county codes)

PARENT(S)/GUARDIAN'S PHONE NO.: Enter telephone number of parent(s) or guardian.

HOSPITAL DHEC NO.: Enter hospital medical record number or DHEC Patient Number.

BABY'S DOCTOR (NUMBER): Enter the number assigned by the State Board of Medical Examiners of South Carolina preceded by the letter "M". If in a group of physicians enter the number assigned by the Bureau of Laboratories preceded by the letter "G".

BABY'S DOCTOR: Enter doctor's name, Street Address, City, and State

BILLING NUMBER: Used by Health Department.

PROGRAM NUMBER: Used by Health Department

HOSPITAL SENDER NO. OR HEALTH DEPT. NO: Enter the sender number. If a hospital, enter the number assigned by the Bureau of Laboratories preceded by the letter "H".

HOSPITAL NAME/HEALTH DEPT.: Enter hospital or health department name.

STREET ADDRESS: Enter hospital or health department street address.

CITY, STATE, ZIP: Enter hospital or health department, city, state and zipcode.

NBS TEST PANEL REQUESTED: Check whether it is the 1<sup>st</sup> NBS TEST PANEL or a REPEAT NBS TEST PANEL. (Do not mark in this area if a whole panel is not requested. Use section under REPEAT – INDIVIDUAL TEST ONLY for any other requests.)

#### REPEAT – INDIVIDUAL TEST ONLY

Mark only the repeat test(s) requested. Individual test(s) should only be marked if one or more of the first tests were abnormal or if the doctor would like a test repeated.

*NOTE: PKU is only one of the NBS panel tests. Marking PKU when ALL tests are needed will mean a complete screening will NOT be performed.*

DATE OF BIRTH: Enter baby's date of birth. Enter month, day, and year. Precede all numbers less than ten (10) with a zero (0). Example: September 1, 2004 would be 09/01/04.

**TIME:** Enter time of birth (hour and minute). **USE MILITARY (24 HOUR CLOCK) TIME.** Precede all numbers less than ten (10) with a zero (0). Examples: 9:20 am would be 09:20. 9:20 pm would be 21:20.

**SEX:** Enter 1 for Male and 2 for Female in the block.

**RACE:** Insert appropriate number in block as outlined below:

- |                     |                    |
|---------------------|--------------------|
| 1. White            | 4. Asian           |
| 2. African-American | 5. American Indian |
| 3. Hispanic         | 6. Other           |

**MOTHER'S SOCIAL SECURITY NUMBER:** Enter mother's social security number.

**BIRTH WEIGHT IN GRAMS:** Enter weight of baby at birth in GRAMS.

**PRESENT WEIGHT IN GRAMS:** Enter weight of baby at time of specimen collection in GRAMS.

**MULTIPLE BIRTHS:** Mark an "X" in the appropriate box Yes or No.

**TRANSFUSED:** Check the box **ONLY** if the infant has had an exchange or transfusion or if he/she has received any blood product containing red cells. The date transfused must be entered (month, day, and year). Baby should be considered transfused if he or she has received red blood cells within the last 2 months.

**FEEDING:** Check the appropriate box

**DATE COLLECTED:** Enter month, day, and year specimen was collected. Precede all numbers less than ten (10) with a zero (0). Example: September 1, 2004 would be 09/01/04.

**TIME OF COLLECTION:** Enter time of collection (hour and minute). **USE MILITARY (24 HOUR CLOCK) TIME.** Precede all numbers less than ten (10) with a zero (0). Examples: 9:20 am would be 09:20. 9:20 pm would be 21:20.

**THE FORM:** The form is made up of three parts.

Part 1: Lab copy. **DO NOT** detach.

Part 2: Sender's copy can be retained by the sender.

Part 3: The Cover, along with Part 1, must stay attached and be returned to the laboratory. The flap over the dried blood spots must cover the spots when the NBS form is placed in the envelope for mailing.

**DO NOT USE TAPE or STAPLES** on the form. **DO NOT USE** an addressograph on the form. The addressograph can compress the filter paper and mar the blood.

**OFFICE MECHANICS AND FILING:** After processing in the laboratory, a computer-generated report will be mailed to the sender(s) and the laboratory will retain the original paperwork.