

## How To: Demographic Information

The blood collection kit includes the form which must be completed. The form is attached to the filter paper which contains five circles on which capillary blood is to be spotted. These forms cannot be copied and must be attached to the filter paper. Use a ball point pen and press firmly to assure legibility of all copies when completing these forms.

### Initial Specimen and Form Completion

The first time a specimen is taken on any child it should be submitted on an **IEM-1** form. The following fields must be completed:

- |                        |                                  |                                |
|------------------------|----------------------------------|--------------------------------|
| 1. Antibiotic          | 6. Gender                        | 11. Multiple birth             |
| 2. Baby's last name    | 7. Gestational age               | 12. Physician name and address |
| 3. Birth date and time | 8. Hospital name and address     | 13. Sample date and time       |
| 4. Birthweight         | 9. Mother's age                  | 14. Transfusion status         |
| 5. Ethnicity           | 10. Mother's contact information | 15. Type of feeding            |

BABY'S LAST NAME (PRINT) _____		EN 21100001 <small>DO NOT WRITE IN THIS AREA</small>	
Birth Date _____	Date of Sample _____	Type of Feeding <input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other _____	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Time <input type="checkbox"/> am <input type="checkbox"/> pm	Sample Time <input type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input type="checkbox"/> Yes If Yes, A, B, C, etc.: _____	BABY'S MEDICAL RECORD NO. _____
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birthweight _____ gms	Transfusion PRIOR to sample collection? If Yes, give date and time: _____	Remarks _____
MOTHER'S NAME (LAST, FIRST) (PRINT) _____		Gestational Age _____ wks	<b>New Jersey Department of Health</b>  <b>INITIAL NEWBORN SCREENING REQUEST</b>
Address _____ Apt. # _____		Mother's Age _____	
City, State, Zip _____		Mother's Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian	4 <input type="checkbox"/> American Indian/Alaskan Native 5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 8 <input type="checkbox"/> Other
HOSPITAL NAME AND ADDRESS _____		BABY'S PHYSICIAN NAME AND ADDRESS _____	
Telephone No. _____		Telephone No. _____	
IEM-1 JUL 19 PerkinElmer 226 Ahlstrom LOT 114068 / 30310003 2025-09-30		SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician H5782	
		NJDOH/NBS LAB COPY	

21100001

EN 21100001

Completely fill 5 circles with blood.

### Repeat Specimen and Form Completion

When collecting a repeat specimen, which has been requested by the IEM laboratory or the physician, use the **IEM-1A** form.

- |                     |                                 |                               |
|---------------------|---------------------------------|-------------------------------|
| 1. Antibiotic       | 5. Gender                       | 9. Physician name and address |
| 2. Baby's last name | 6. Hospital name and address    | 10. Sample date and time      |
| 3. Birth date       | 7. Multiple birth               | 11. Transfusion status        |
| 4. Birthweight      | 8. Mother's contact information | 12. Type of feeding           |

BABY'S LAST NAME (PRINT) _____		EN 19400001 <small>DO NOT WRITE IN THIS AREA</small>	
Birth Date _____	Date of Sample _____	Type of Feeding <input type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other _____	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Sample Time <input type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, A, B, C, etc.: _____	NICU/SCN? <input type="checkbox"/> Yes <input type="checkbox"/> No
Birthweight _____ gms	Antibiotic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Transfusion PRIOR to sample collection? If Yes, give date and time: _____	Remarks _____
MOTHER'S NAME (LAST, FIRST) (PRINT) _____		Collector's Initials / Date: _____	
Address _____ Apt. # _____		Mother's Telephone No. _____	
City, State, Zip _____		BABY'S PHYSICIAN NAME AND ADDRESS _____	
HOSPITAL NAME AND ADDRESS _____		Telephone No. _____	
Telephone No. _____		Telephone No. _____	
IEM-1A JAN 16 PerkinElmer 226 Ahlstrom LOT 112147 / 30320002 2025-04-30		SPECIMEN SUBMITTED BY: <input type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician H5783	
		NJDOH/NBS LAB COPY	

19400001

EN 19400001

Completely fill 5 circles with blood.

*\*If items in blue are missing, the sample is considered demographically unacceptable, as the laboratory cannot properly evaluate results or contact the correct healthcare providers or the families in the event of a positive screen. A specimen missing this information will be tested, but test results will contain a disclaimer explaining the missing information. It is critical to provide accurate information on this form.*

## Item-by-Item Instructions for Completing the Specimen Collection Forms

Item	Instructions	Item	Instructions
<b>Baby's Last Name</b>	Enter baby's last name <u>only</u> . Please note if the baby and mother have different last names.	<b>*Transfusion Status</b>	Check yes or no. If yes, provide <u>month, day, year of last transfusion</u> . This only refers to whole blood, packed red blood cells or intrauterine transfusion. <u>Plasma and platelets are not considered transfusions.</u>
<b>*Birth Date</b>	Fill in month, day, year. Do <u>not</u> leave this field blank.	<b>*Gestational Age</b>	Write in full weeks.
<b>*Birth Time</b>	Write in military time.	<b>*Mothers Name</b>	Write mother's first name and last name. Include middle initial when applicable
<b>*Date of Sample</b>	Fill in month, day, year. Do <u>not</u> leave this field blank.	<b>Mothers Age</b>	Write mother's age. Be sure to not confuse this item with gestational age.
<b>*Sample Time</b>	Write in military time.	<b>*Mother's Address</b>	Write street and Number, City, State, Zip Code (9 digits)
<b>Type of Feeding</b>	Check breast, bottle, HAL/TPN, or other. Check both if baby is on breast and bottle. If other, please designate.	<b>Mother's Race</b>	Check the appropriate box. Requested by the CDC for seroprevalence study.
<b>Antibiotic</b>	Check yes or no.	<b>Mother's Hispanic Origin</b>	Check yes or no.
<b>Baby's MRN</b>	Enter baby's medical record number. Omit <u>only</u> if collection of specimen was not in a hospital.	<b>*Mother's Telephone</b>	Telephone number If none, provide the phone number of a family member or friend
<b>NICU/SCN</b>	Check yes or no.	<b>*Hospital of Birth Name and Address</b>	Enter hospital name, street and number, city, state, zip code, and telephone number
<b>Multiple Birth</b>	Check yes or no; and identify baby A, B, C, etc. Do not indicate baby A for single birth.	<b>*Ordering Physician First and Last Name and Address</b>	Enter physician's <u>full name</u> or pediatric group, street and number, city, state, zip code, and telephone number
<b>*Gender</b>	Check Male or Female.	<b>Collectors Initials</b>	Initial and date
<b>*Birthweight</b>	Write in grams. Do not provide measurements in pounds and ounces	<b>Specimen submitted by</b>	Select hospital or physician

*\*Items that are essential for specimen testing and reporting*

## Evaluating Demographic Information

### Quality of Kit and Kit information

#### Specimen not attached to form

Inspect to ensure that the filter paper with the spots is attached to the form with the demographic information.

#### Specimen arrived in lab > 14 days from collection date

Inspect the date of specimen collection. Date of specimen collection must be within fourteen days of receipt in the laboratory to be valid for testing.

#### Conflicting information

Inspect demographic information for any conflicting information. If the identity of the baby to whom the blood spots belong is in question the blood will not be tested. Do not use white out on any demographic fields. For any errors, strikethrough with pen and add corrections to the remarks section.


#### Filter paper expired

Inspect the expiration date of the filter paper. Filter paper expiration date is located along the left side of the kit, in the green or yellow colored region, and along the bottom under the box for hospital information. Specimen collected on expired filter paper are not valid for testing.

## What does the ideal top copy look like?

All fields are legibly and adequately filled. All information provided corresponds with the recommended guidelines. The kit is not expired or damaged. Any corrections are crossed out with a line and correct information is noted in the Remarks box.

BABY'S LAST NAME (PRINT) Kelly		SN 21100001		DO NOT WRITE IN THIS AREA	
Birth Date 2 16 22	Date of Sample 2 17 22	Type of Feeding <input checked="" type="checkbox"/> Breast <input type="checkbox"/> HAL/TPN <input type="checkbox"/> Formula <input type="checkbox"/> Other	Antibiotic? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	BABY'S MEDICAL RECORD NO. 1002014231	
Birth Time 0300 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	Sample Time 0330 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	Multiple Birth? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, A, B, C, etc.: B		Remarks Transfusion = no
Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Birthweight 3476 gms	Transfusion PRIOR to sample collection? If Yes, give date and time: <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes: <del>2/17/22</del>		Gestational Age 39 wks	New Jersey Department of Health  INITIAL NEWBORN SCREENING REQUEST
MOTHER'S NAME (LAST, FIRST) (PRINT) Lorem, Ipsum		Mother's Age 28	Collector's Initials / Date: AB 2/17/22		
Address 52 Dolor Sit Amet Rd Apt. 2		City, State, Zip Consectetur NJ 07022	Mother's Race 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian	4 <input type="checkbox"/> American Indian/Alaskan Native 5 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 8 <input checked="" type="checkbox"/> Other	Mother's Telephone No. 132-643-2354
HOSPITAL NAME AND ADDRESS My Medical Center 1 Adipsicing Rd Laoreet Augue, NJ 01234 Telephone No. 104-294-1924			BABY'S PHYSICIAN NAME AND ADDRESS Dr. Ullamcorper 1 Adipsicing Rd Laoreet Augue, NJ 01234 Telephone No. 104-364-1224		
IEM-1 JUL 19 PerkinElmer 226 Ahlstrom LOT 114068 / 30310003 2025-09-30		SPECIMEN SUBMITTED BY: <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Baby's Physician		H5782	
NJDOH/NBS LAB COPY					



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