

WISCONSIN NEWBORN SCREENING SPECIMEN COLLECTION FORM

DATES/TIMES (Military):
Enter as MMDDYY 00:00

BABY'S NAME (LAST, FIRST):
Enter name at time of collection

MOTHER OR GUARDIAN (LAST, FIRST):
Enter name as **last, first**.
In cases of surrogacy, adoption, etc. enter the name of the baby's guardian.

GESTATIONAL AGE: Enter the gestational age **at time of birth** in weeks (wks) and days.
Do NOT add current age to gestational age.

SUBMITTER LABEL/BARCODE:
This label indicates the entity collecting the specimen.

ALL FIELDS ARE **REQUIRED** AND **CRITICAL FOR IDENTIFICATION OR RESULT INTERPRETATION**

MULTIPLE BIRTH:
For twins, triplets, etc.
(#1 of 2, #2 of 2, etc.)

BABY'S PCP/NPI#/CLINIC/PHONE#:
Enter the last **and** first names of the baby's primary care provider, NPI#, clinic name and city, and clinic phone #.
This field is critical for follow-up and reporting of results.

BABY ON TPN NOW:
Circle **N** or **Y**. Circle **Y** if baby is on Total Parenteral Nutrition or any amino acid supplement at time of collection.

TRANSFUSION(S): Circle **N** or **Y**.
Collection should be performed prior to transfusion. If baby has been transfused, enter date and time of LAST transfusion. If baby was transfused *in utero*, circle **Y** and record "prior to birth" if date is unknown.

PRINT LEGIBLY AND ACCURATELY

BLOOD NOT SUBMITTED: Submission of a completed card from the place of birth is **required** for every baby regardless if a collection was performed. Indicate reason for no blood submission:

- Blood screening is **DECLINED** due to religious beliefs or personal convictions
- Baby is **DECEASED** (specify date)
- Baby was **TRANSFERRED** to another facility prior to collection (specify facility)
- **OTHER** (specify reason)

NEVER transfer card with baby

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FORM EXPIRATION

DATE: Collection must be made prior to this date.

BABY IN ICU?:

Circle No or Yes.
IF yes, please refer to the WSLH NBS website for ICU collection protocol.
Check box IF this is the discharge collection.

PLACE OF BIRTH:

Enter facility name or "Home Birth" along with city and state where the baby was born.
"Home Birth" should be entered for any birth outside of a birth facility.



PRINT LEGIBLY AND ACCURATELY

Submitter User/Label: UXXXXXX

Baby's Name (LAST / FIRST): LAST FIRST Multiple births (Twin, etc.) # OF F M SEX Baby's Birthdate Time (Military) MM / DD / YY :

Baby's ID # (MRN/Ait. ID): Baby's Primary Care Provider: LAST FIRST NPI#

Specimen Collection Date Time (Military) PCP's Clinic Name City Phone # ()

Mother OR Guardian Name (LAST / FIRST): LAST FIRST Ordering Physician: LAST FIRST NPI#

Weight at birth (grams) g Gestational age at birth wks days Baby's Race (Circle all that apply) Black Native American White Asian/Pacific Isle Hispanic? N Y

Baby in ICU? Collection at Discharge Repeat Specimen? N Y Transfusion(s)? (any product) N Y Baby on TPN now? N Y Last Txn Date/Time:

Place of Birth (required) NAME CITY / STATE Mother's Hepatitis B Surface Antigen: (HBsAg): Neg Pos

Blood Not Submitted (mark reason) Declined Transferred Deceased Other Pulse Ox Screen Date Time (Military) MM / DD / YY : Pass Fail

Hearing Screen Date Not Screened (mark reason) Declined Transferred Deceased Other

Circle Hearing Screen Method Right Ear Pass Refer Left Ear Pass Refer Hearing Not Screened (mark reason) Transferred NICU Declined Deceased Other

This box for Newborn Screening Laboratory USE ONLY

Please fill out the form entirely with LEGIBLE and ACCURATE information. FORM EXPIRATION DATE: 2026-09-30

PARENTS COPY FORM EXPIRATION DATE: 2026-09-30 Do not place cover over circles

BABY'S RACE: Circle race of baby. If baby is of mixed race, circle all that apply.

MOTHER'S HEP B SURFACE ANTIGEN (HBsAg): Circle **NEG** if mother's test result is non-reactive or negative. Circle **POS** if mother's test is reactive or positive. Do not confuse hepatitis B *antibody* results for hepatitis B *surface antigen* results.
This field is critical for proper immunization of babies born to HBsAg-positive mothers.

HEARING SCREEN DATE: Enter date as MMDDYY
and METHOD: Circle method(s) used
and RESULT: Circle result Pass OR Refer (only one result per ear)
HEARING NOT SCREENED: If hearing screening was not performed, check reason. If **Other**, please specify.

PULSE OX SCREEN DATE / TIME: Enter date as MMDDYY and time in military time **and RESULT:** Check only one box (Pass OR Fail).
NOT SCREENED: If pulse ox screening was **not** performed, check reason listed. If **Other**, please specify.

IMPORTANT:
Reporting of pulse ox or hearing results should NEVER delay the submission of a blood card.
If hearing and/or pulse oximetry screening results are not provided on the initial blood card, results should be submitted to WETRAC, not WSLH. For WETRAC questions please email the Department of Health at DHSWETRAC@wisconsin.gov

EVERY BABY BORN IN WISCONSIN IS REQUIRED TO HAVE A NEWBORN SCREENING CARD COMPLETED.