

Iowa Newborn Screening Program New Dried Bloodspot Collection Card



On 9 March 2016, a healthcare worker takes a dried blood spot (DBS) sample from six-week old baby, at Matapila Health Center, in Lilongwe, Malawi. DBS are transported to a central lab for testing. Photo Courtesy of UNICEF

COME SEE THE NEW CHANGES!

ASK QUESTIONS AND HEAR FROM OTHER SUBMITTERS

Scan the QR code or click the link to register.

https://uiowa.zoom.us/webinar/register/WN_7G-Jg89UTBOsmO4LD1m0JA



SEPTEMBER 26TH, 11:00 AM-12:00 PM

New Newborn Screening Dried Bloodspot Collection Card Educational Webinar

The Iowa Newborn Screening Program has revised the dried bloodspot collection card and we want to share the changes with you! Please join us to learn about the changes and ask questions.

Iowa Newborn Screening Program Form		2029-05-31	IA2015901
903™ Expiration Date: 2029-05-31 IVD IOWA	<input type="checkbox"/> Initial Screen <input type="checkbox"/> Repeat Screen <input type="checkbox"/> Mother's Screen Infant's Last Name: _____ Infant's First Name: _____ Infant's Birth Date: _____ Infant's Birth Time (24 hour clock): _____ Infant's Gender: <input type="checkbox"/> M <input type="checkbox"/> F Infant's Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown/Other 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 Transfused Before Collection ANY Blood Products: <input type="checkbox"/> Yes <input type="checkbox"/> No If Applicable, Date of Last Transfusion: _____ Infant's Street Address: _____ City: _____ State: _____ Zip Code: _____ Check if infant is in NICU: <input type="checkbox"/> Check if infant has Meconium Ieus: <input type="checkbox"/>	1034639 Rev AD REF 7309724 W221 LOT IA2015901 INSP USE ONLY 2029-05-31 Completely Fill All Circles With Blood ALLOW TO AIR DRY FOR AT LEAST 3 HOURS DO NOT HEAT 903™	IA2015901 IA2015901
	Guardian: <input type="checkbox"/> Mother <input type="checkbox"/> Other (Please Specify) _____ Guardian Birth Date: _____ Guardian Gender: <input type="checkbox"/> M <input type="checkbox"/> F Guardian Phone Number: _____ 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: _____ <input type="checkbox"/> Check if same as above - Primary Care Provider's Last Name: _____ Primary Care Provider's First Name: _____ Primary Care Provider's Phone Number: _____ Submitting Facility Name: _____ DO NOT WRITE IN THIS SPACE Submitting Facility Street Address: _____ City: _____ State: _____ Zip Code: _____		