

2010 Newborn Screening Collection Kits

PAGE 2 OF KIT - DETACH AND GIVE TO PARENT FOR REVIEW

<p>Use and Storage of Newborn Screening Blood Spot Cards PARENT / MANAGING CONSERVATOR / LEGAL GUARDIAN PLEASE READ CAREFULLY</p> <p>What is newborn screening? The Texas Newborn Screening Program checks Texas babies for a list of serious medical conditions. These conditions can cause death or severe disability. Finding a medical problem during newborn screening can help prevent problems and may save your baby's life.</p> <p>How does your baby get screened? A small amount of your baby's blood is placed on a special blood spot card. The blood spot card is sent to the state laboratory and tested.</p> <p>What happens after the blood is tested? After testing, blood spot cards are safely stored by the Texas Department of State Health Services (DSHS) because they still have important public health uses. The main uses are: 1) quality assurance/quality control, such as making sure that testing equipment continues to produce accurate newborn screening test results for Texas babies, and 2) medical research [see Texas Health and Safety Code Sec. 33.017(b)-(c) for a complete list of uses allowed by law]. Specific information that could identify your child and connect him/her to a particular blood spot card is not allowed outside of DSHS without permission from the child's parent, managing conservator, or legal guardian unless otherwise provided by law.</p> <p>You can have your baby's blood sample destroyed if you do not want it to be used after the newborn screening tests are completed. If you are okay with the sample being stored and used, as described above, then there are no further steps for you to take.</p> <p>If you want your baby's blood sample to be destroyed, YOU must fill out ALL of the information on this form and send it back to DSHS at the address given below (DSHS will also accept the form from your healthcare provider, once you have completed and signed the form). If the newborn screening blood spot card is destroyed, the blood sample will not be available for any future needs you may have for the sample.</p> <p>To Request to have your child's blood spot(s) destroyed:</p> <ol style="list-style-type: none"> Fill out the entire attached form. Do not leave any fields blank. Mail original to: Texas Department of State Health Services Newborn Screening Laboratory, MC 1947 PO Box 149347 Austin, Texas 78714-9347 For additional information, call 1(888) 963-7111 ext. 7333 or visit web site: http://www.dshs.state.tx.us/lab/newbornscreening.shtm <p>DSHS Laboratory Services Section - NBS Form F14-13230 - February 2010</p>	<p>Directive to Destroy Newborn Screening Blood Spot Card Following Testing</p> <p>Fill out this form ONLY if you WANT your baby's blood sample destroyed after newborn testing is complete</p> <p>I, _____ (please print full name) hereby certify that I am the (check one) <input type="checkbox"/> parent, <input type="checkbox"/> managing conservator, or <input type="checkbox"/> legal guardian of the child named below, and I further certify that there is no court order in effect which restricts my legal ability to make this request.</p> <p>As parent, managing conservator, or legal guardian, I am telling DSHS to destroy my child's blood spot card(s) after the newborn screen testing is finished.</p> <p>Full Name of Child: _____</p> <p>Child's Date of Birth: _____</p> <p>Full Name of Mother: _____</p> <p>Contact Information: _____ (Telephone number, e-mail address)</p> <p>_____ (Mailing address)</p> <p>_____ (City, State, Zip)</p> <p>Check here <input type="checkbox"/> to instruct DSHS to destroy NBS specimens from the child named above.</p> <p>_____ (Signature) _____ (Date)</p> <p>I hereby certify, under penalty of law that all the information I have provided herein is true and accurate. I understand that providing false information on this form constitutes a crime in Texas under Penal Code Sec. 37.09.</p>
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Provider: Detach this Page and Give to Parent for Review

PAGE 3 OF KIT - DEMOGRAPHIC INFORMATION SHEET

<p>INSURANCE TEXAS DEPARTMENT OF STATE HEALTH SERVICES Laboratory Services Section CLIA#45D0660644 FORM NBS 4 Rev 03/10 Expires 04/02/2013. Telephone # (800) 252-8023 ext. 7318</p>		<p>Please read the instructions on the back of this form before starting. USE BLACK INK. PRINT INFORMATION COMPLETELY, ACCURATELY, & LEGIBLY IN BLOCK CAPITAL LETTERS.</p>																																					
<p>MOTHER INFORMATION</p> <p>Mother's Last Name _____ Mother's First Name _____ Maiden Name _____ Social Security # _____ Mother's Birth Date <u>MM/DD/YY</u> Street Address _____ APT. No. _____ City _____ Zip Code _____ State _____ Best Phone Number to Reach Mother _____ Newborn Father's Last Name _____</p>		<p>DSHS Lab No. _____ For Texas DSHS Use Only</p> <p>SPECIMEN REJECTED if NO Date of Collection or NO Newborn's Last Name is provided.</p> <p>NEWBORN INFORMATION</p> <p>Newborn's Last Name _____ First Name/Twin A or B _____ Medical Record No. _____ Birth Order (1-9), if Multiple <u>MM/DD/YY</u> Military Time _____ Birthweight (grams) _____ Previous Specimen Serial Number _____ Collection Date <u>MM/DD/YY</u> Military Time _____</p> <table border="1"> <tr> <th>Sex</th> <th>Ethnicity</th> <th>Status</th> <th>Baby's Age at Time of Collection / Test</th> </tr> <tr> <td>1. Male <input type="checkbox"/></td> <td>1. White <input type="checkbox"/></td> <td>0. Normal <input type="checkbox"/></td> <td>1. Less than 7 days old <input type="checkbox"/></td> </tr> <tr> <td>2. Female <input type="checkbox"/></td> <td>2. Af. Amer. <input type="checkbox"/></td> <td>1. Sick/Premature <input type="checkbox"/></td> <td>2. 7 days or older <input type="checkbox"/></td> </tr> <tr> <td></td> <td>3. Hispanic <input type="checkbox"/></td> <td>2. On Medications <input type="checkbox"/></td> <td>3. Previous Abnormal: Enter Texas DSHS Laboratory No. _____</td> </tr> <tr> <td>1. Breastmilk only <input type="checkbox"/></td> <td>4. Asian <input type="checkbox"/></td> <td>3. Transfused <input type="checkbox"/></td> <td></td> </tr> <tr> <td>2. Formula only <input type="checkbox"/></td> <td>5. Am. Indian <input type="checkbox"/></td> <td>4. Both 1 & 2 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>3. TPN ± Milk <input type="checkbox"/></td> <td>6. Other <input type="checkbox"/></td> <td>5. Both 1 & 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td>4. Breastmilk & Formula <input type="checkbox"/></td> <td></td> <td>6. Both 2 & 3 <input type="checkbox"/></td> <td></td> </tr> <tr> <td></td> <td></td> <td>7. All 1-3 <input type="checkbox"/></td> <td></td> </tr> </table>		Sex	Ethnicity	Status	Baby's Age at Time of Collection / Test	1. Male <input type="checkbox"/>	1. White <input type="checkbox"/>	0. Normal <input type="checkbox"/>	1. Less than 7 days old <input type="checkbox"/>	2. Female <input type="checkbox"/>	2. Af. Amer. <input type="checkbox"/>	1. Sick/Premature <input type="checkbox"/>	2. 7 days or older <input type="checkbox"/>		3. Hispanic <input type="checkbox"/>	2. On Medications <input type="checkbox"/>	3. Previous Abnormal: Enter Texas DSHS Laboratory No. _____	1. Breastmilk only <input type="checkbox"/>	4. Asian <input type="checkbox"/>	3. Transfused <input type="checkbox"/>		2. Formula only <input type="checkbox"/>	5. Am. Indian <input type="checkbox"/>	4. Both 1 & 2 <input type="checkbox"/>		3. TPN ± Milk <input type="checkbox"/>	6. Other <input type="checkbox"/>	5. Both 1 & 3 <input type="checkbox"/>		4. Breastmilk & Formula <input type="checkbox"/>		6. Both 2 & 3 <input type="checkbox"/>				7. All 1-3 <input type="checkbox"/>	
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<p>BABY'S PRIMARY CARE PHYSICIAN INFORMATION</p> <p>Physician Name (Last, First) _____ NPI No. _____ Street Address _____ Apt No. _____ City _____ Zip Code _____ State _____ Phone No. _____ Fax No. _____</p>		<p>SUBMITTER INFORMATION</p> <p>NBS ID No. _____ / NPI No. _____ Name _____ Address _____ City _____ TX _____ Zip Code _____</p> <p>Check to verify disclosure, and destruction option, distributed. <input type="checkbox"/></p>																																					

Check here to verify disclosure.



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