

INSTRUCTIONS

1. Georgia's Newborn Screening Program tests for Biotinidase Deficiency, CAH, Galactosemia, Homocystinuria, Hypothyroidism, MSUD, MCAD*, PKU, Sickle Cell Disease and Tyrosinemia between 48 hours and 1 week of life. A specimen must be collected on all infants, regardless of age, prior to discharge from the hospital. If the discharge is before 48 hours of age, a repeat specimen is necessary within 7 days.
2. When collecting blood, fold back sheet to expose filter paper. Do not touch or handle filter paper before or after applying blood.
3. See diagram for puncture site. Avoid previous puncture sites or curvature of the heel.
4. Warm heel for three minutes.
5. Cleanse puncture site with 70% alcohol.
6. Allow the skin to air dry.
7. Make puncture using sterile lancet with tip not longer than 2.44 mm.
8. Wipe away first drop of blood with dry sterile gauze.
9. Allow second, larger drop of blood to form.
10. Gently apply filter paper to large drop of blood. Allow blood to soak through and completely fill preprinted circle. Apply blood to one side of filter paper only. (Either side may be chosen for procedure.) **Do not use capillary tubes for specimen collection.**
11. Fill circle with **single** application to drop of blood. Do not layer successive drops of blood.
12. Fill all six circles.
13. Exercise extreme caution to avoid touching the special absorbent paper used for collecting the blood specimen. **Only blood should come in contact with this page.**
14. **Allow blood spots to thoroughly air dry for at least 4 hours** on a flat, nonabsorbent surface, away from direct heat and sunlight. Avoid touching or smearing blood spots. Never superimpose one filter paper on another before thoroughly drying. Do not refrigerate.
15. The State Laboratory assumes responsibility for testing only; whoever submits specimens must assume liability for proper identification, collection and prompt delivery of specimens to the State Laboratory.
16. Test results will be computer generated.
17. Store filter paper forms in a cool, dry place.
18. Order no more filter paper forms than can be used in 6 months.
19. When placing more than one specimen in an envelope, alternate forms so that blood spots on adjacent forms are not in contact.
20. Ship completed collection forms to the testing laboratory within 24 hours of collection. Ship specimen to: **GA Public Health Laboratory
1749 Clairmont Road
Decatur, GA 30033-4053**



Preferred puncture site is indicated by shaded area on heel.

*Beginning in 2005

NEWBORN SCREENING UNIT
 GDHR PUBLIC HEALTH LAB
 Metabolic and Sickle Cell Disease

GA STATE LAB USE ONLY
 DO NOT WRITE IN THIS SPACE

1.QNS 2. Oversat 3. Delayed 4. Contam.
 5. Uneven Soak 6. Cap 7.OBS 8. Crump.
 9. Retest-48hrs collection 10. RU 11.NB
 12. II 13. Blood reattachment to form

Submitter's Code		Birth Hospital				Physician License Number	
Infant's Last Name		Infant's Physician's Name					
Infant's First Name		Infant's Physician's Address					
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male		Birth Weight (grams) Check <input type="checkbox"/> wks		City, State		Zip Code	
Birth Date		Birth Time (24 Hr)		Telephone Number		Fax Number	
<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C		Baby's Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multiracial <input type="checkbox"/> Unknown		Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No			
Infant's Medical Record Number		Primary feeding: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Both <i>If formula, trade name:</i> _____		Transfusion: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, date:</i> ___/___/___			
Mother's Last Name		Mother's First Name				<input type="checkbox"/> 1 st Test <input type="checkbox"/> Retest -Prior Unsatisfactory <input type="checkbox"/> Retest-Prior Abnormal (Requested by State)	
Address		Apt. #		Birth Date			
City		State		County			
Zip Code		Contact Number		Medicaid Number		Date Collected	
						Time Collected (24 Hr)	

SAMPLE