

Newborn Screening Program

Heelstick Monthly Summary Report – Cover Sheet (Page 1 of 3)

Date of submission: _____

Month/year data: _____

Hospital/midwifery name: _____

Address: _____

Completed by: _____

Phone: _____ Fax: _____ E-mail: _____

Check here if your facility's contact information has changed from previous months. This will help ISDH Newborn Screening Program keep e-mail and phone distribution lists current. Thank you!

Screening Statistics (report initial screens only)

Total number of live births this month: _____

Total number of home births that received screening: _____

Total number of walk-ins that received screening: _____

Number of exceptions reported to ISDH this month: _____

Number of screens*: _____

*Number of screens = (live births + home births + walk-ins) MINUS # exceptions reported to ISDH (**including "Finally Screened" & transfers**)

NOTE: Any infants who are discharged HOME without receiving a valid initial newborn screen must be reported immediately by phone to the ISDH Newborn Screening Program (317-233-9260).

Completed reports are due by 5 pm EST on the first business day after the 14th of the following month. Most of the time, MSR's will be due by 5 pm EST on the 15th—however, if the 15th falls on a weekend, MSR's will be due by 5 pm EST the following Monday. Please submit your MSR to:

Courtney Eddy, INSTEP Director

2 N. Meridian Street, 7F, Indianapolis, IN 46204

(317) 234 – 2995 (fax)

Heelstick Exception Reporting Form (page 2 of 3)

Facility:

Month:

For each child who did not receive a newborn screen at your facility this month, please COMPLETE the form below. Items marked with an asterisk (*) are required. Your MSR will not be processed until all required information is complete. Continue on page 2.

Transfer Details a. Not transferred b. Transferred out of your facility c. Transferred into your facility

Exception Details

1. Transfer only 2. Finally screened 3. NICU 4. Initial screen next month 5. Deceased
 6. Religious Refusal 7. Discharged HOME without valid initial newborn screen

Infant #	Infant				Transfer details			Exception Details	
	MRN*	Last name*		DOB*	Gender*	Transfer code*	Name of other facility involved in transfer* (if applicable)	Exception code*	Date of transfer/NBS/ death/ Religious Waiver/discharge
		First name*	Time of birth*	Birth order*					
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Comments (Indicate MRN):

Infant #	<u>Mother</u>				<u>Primary care provider</u>		
	Last name*	Maiden name	Address*	Last name*	Phone*		
	First name*	Phone*	City/State/Zip*	First name*			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Comments (Indicate MRN):