

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 14<sup>th</sup> of the following month.* Most of the time, MSRs will be due by 5 pm EST on the 15<sup>th</sup>—however, if the 15<sup>th</sup> falls on a weekend, MSRs will be due by 5 pm EST the following Monday. Please submit your MSR to:

Eileen White, RN, BSN

(317) 234 – 2995 (fax) / [EWhite1@isdh.IN.gov](mailto:EWhite1@isdh.IN.gov) (Certified/secure e-mail ONLY)

# 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*	Date of transfer* (if applicable)				
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*
	First name*	Phone*	City/State/Zip*	First name*			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Comments (Indicate MRN):