

# Front of Form (Flap Folded)

All measurements can vary +/- 1/16" (1.6mm)  
 Glue lines are between the stubs of parts 1, 2, 3, 4, and 6, and in between part 5 and 6

Dotted Magenta lines signify perf lines.

stub: 7/16"

folded flap: 1 9/16"

PENNSYLVANIA DEPT. OF HEALTH EXPIRES 2018-06	Pennsylvania Department of Health <b>TOP COPY FOR LAB; SUBMITTER MAY KEEP YELLOW COPY</b> Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514		<input type="checkbox"/> Monitor for _____		SN PA151090501	
	<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth → If Multiple: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other: _____	
	Birth Facility Name ("Home" if home birth)		Code		Birth Date    Time: <input type="checkbox"/> AM <input type="checkbox"/> PM    Birth Wt.: _____ <input type="checkbox"/> gms.	
	Submitter Name		Code		Collection Date    Time: <input type="checkbox"/> AM <input type="checkbox"/> PM    Current Wt.: _____ <input type="checkbox"/> gms.	
	Address if no CODE given		Weeks Gest.: _____		Medical Record #: _____	
	BABY'S Name (Last)		BABY'S Name (First)		<b>At Time of Collection:</b> Drawn By: _____	
	MOTHER'S Name (Last)		MOTHER'S Name (First, MI)		<input type="checkbox"/> Transfused    Date: ____/____/____    Time ____:____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Mother's Date of Birth		Mother's Phone # ( ) -		<input type="checkbox"/> NICU <input type="checkbox"/> Hyperal <input type="checkbox"/> Carnitine <input type="checkbox"/> Meconium ileus	
	Street (PO Box)		Newborn PCP / Practice Name		Race (check all that apply):    Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	City    State    Zip		Street (PO Box)		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	
Emergency Contact		Emergency Contact # ( ) -		Newborn PCP / Practice Name		
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		PCP Phone Number ( ) -		Street (PO Box)		
Mother's Medical History:    HBsAg:		City    State    Zip		City    State    Zip		
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Pos.		PCP Phone Number ( ) -		Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed    Date: ____/____/____    Time ____:____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> On Steroids <input type="checkbox"/> Neg.		If not performed √ reason:		<input type="checkbox"/> refused <input type="checkbox"/> transferred <input type="checkbox"/> <24 hrs. <input type="checkbox"/> echo performed		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		AFFIX ACCESSION LABEL HERE		<input type="checkbox"/> prenatal dx <input type="checkbox"/> other _____		



GIVE TO PARENT / LEGAL GUARDIAN

FOLD BACK DURING DRYING BUT **DO NOT REMOVE THIS COVER FLAP.** IT IS FOR THE PROTECTION OF THE SPECIMEN HANDLERS.

**PLEASE MAKE SURE THAT THE BLOOD SPOTS ARE COMPLETELY DRY**

AND PROTECTIVE FLAP IS IN PLACE BEFORE SUBMITTING SPECIMEN



Total Form Height (all parts) 4" (101.60mm)

Total Form Length (Flap Folded) 9 5/8" (244.48mm)

Face of Part 1 (no copy on back)

Dotted Magenta lines signify perf lines.

stub: 7/16"

PENNSYLVANIA DEPT. OF HEALTH EXPIRES 2018-06	Pennsylvania Department of Health <b>TOP COPY FOR LAB; SUBMITTER MAY KEEP YELLOW COPY</b> Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514		<input type="checkbox"/> Monitor for _____		SN PA151090501	
	<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth → If Multiple: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other: _____	
	Birth Facility Name ("Home" if home birth)		Code		Birth Date    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Birth Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Submitter Name		Code		Collection Date    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Current Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Address if no CODE given		Weeks Gest.: _____		Medical Record #: _____	
	BABY'S Name (Last)		BABY'S Name (First)		<b>At Time of Collection:</b> Drawn By: _____	
	MOTHER'S Name (Last)		MOTHER'S Name (First, MI)		<input type="checkbox"/> Transfused    Date: ____/____/____    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Mother's Date of Birth		Mother's Phone # ( ) -		<input type="checkbox"/> NICU <input type="checkbox"/> Hyperal <input type="checkbox"/> Carnitine <input type="checkbox"/> Meconium ileus	
	Street (PO Box)		Newborn PCP / Practice Name		Race (check all that apply):    Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	City    State    Zip		Street (PO Box)		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	
Emergency Contact		Emergency Contact # ( ) -		Newborn PCP / Practice Name		
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		City    State    Zip		PCP Phone Number ( ) -		
Mother's Medical History:    HBsAg:		City    State    Zip		Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed    Date: ____/____/____    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Pos.		PCP Phone Number ( ) -		If not performed √ reason:		
<input type="checkbox"/> On Steroids <input type="checkbox"/> Neg.		City    State    Zip		<input type="checkbox"/> refused <input type="checkbox"/> transferred <input type="checkbox"/> <24 hrs. <input type="checkbox"/> echo performed		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		City    State    Zip		<input type="checkbox"/> prenatal dx <input type="checkbox"/> other _____		



Total Form Height (all parts) 4" (101.60mm)

Part 1: 16# White CB, black and red 185 ink face only, 3/16" black press number, Code 3 of 9 barcode with Mod 43 check digit contained in barcode 7 3/4" (196.8mm)

Face of Part 2 (copy on back)

Dotted Magenta lines signify perf lines.

stub: 7/16"

PENNSYLVANIA DEPT. OF HEALTH EXPIRES 2018-06	Pennsylvania Department of Health <b>PARENT COPY: INSTRUCTIONS ON BACK</b> Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514		<input type="checkbox"/> Monitor for _____		SN PA151090501	
	<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth → If Multiple: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other: _____	
	Birth Facility Name ("Home" if home birth)		Code		Birth Date    Time: <input type="checkbox"/> AM <input type="checkbox"/> PM    Birth Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Submitter Name		Code		Collection Date    Time: <input type="checkbox"/> AM <input type="checkbox"/> PM    Current Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Address if no CODE given		Weeks Gest.:		Medical Record #:	
	BABY'S Name (Last)		BABY'S Name (First)		<b>At Time of Collection:</b> Drawn By: _____	
	MOTHER'S Name (Last)		MOTHER'S Name (First, MI)		<input type="checkbox"/> Transfused    Date: ____/____/____    Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Mother's Date of Birth		Mother's Phone # ( ) -		<input type="checkbox"/> NICU <input type="checkbox"/> Hyperal <input type="checkbox"/> Carnitine <input type="checkbox"/> Meconium ileus	
	Street (PO Box)		Newborn PCP / Practice Name		Race (check all that apply):    Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	City    State    Zip		Street (PO Box)		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	
Emergency Contact		Emergency Contact # ( ) -		Newborn PCP / Practice Name		
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		City    State    Zip		PCP Phone Number ( ) -		
Mother's Medical History:    HBsAg:		City    State    Zip		Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed    Date: ____/____/____    Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Pos.		City    State    Zip		If not performed √ reason:		
<input type="checkbox"/> On Steroids <input type="checkbox"/> Neg.		City    State    Zip		<input type="checkbox"/> refused <input type="checkbox"/> transferred <input type="checkbox"/> <24 hrs. <input type="checkbox"/> echo performed		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		City    State    Zip		<input type="checkbox"/> prenatal dx <input type="checkbox"/> other _____		



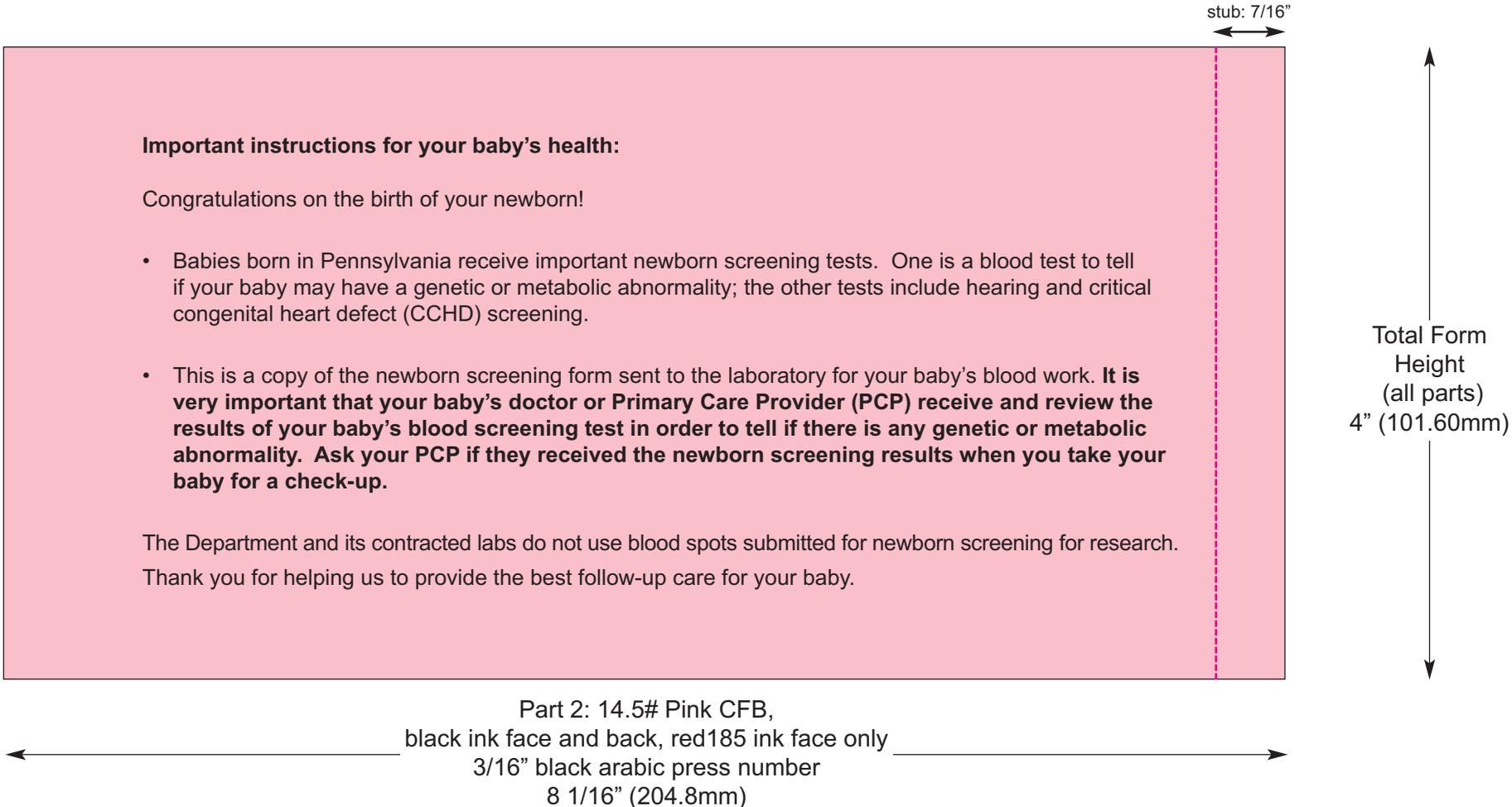
GIVE TO PARENT / LEGAL GUARDIAN

Total Form Height (all parts) 4" (101.60mm)

Part 2: 14.5# Pink CFB, black ink face and back, red185 ink face only  
 3/16" black arabic press number  
 8 1/16" (204.8mm)

# Back of Part 2 (copy on front)

----- Dotted Magenta lines signify perf lines.



Face of Part 3 (no copy on back)

Dotted Magenta lines signify perf lines.

stub: 7/16"

PENNSYLVANIA DEPT. OF HEALTH EXPIRES 2018-06	<b>Pennsylvania Department of Health</b> Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514		<input type="checkbox"/> Monitor for _____		SN PA151090501	
	<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth → If Multiple: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other: _____	
	Birth Facility Name ("Home" if home birth)		Code		Birth Date    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Birth Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Submitter Name		Code		Collection Date    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM    Current Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Address if no CODE given		Weeks Gest.: _____		Medical Record #: _____	
	BABY'S Name (Last)		BABY'S Name (First)		<b>At Time of Collection:</b> Drawn By: _____	
	MOTHER'S Name (Last)		MOTHER'S Name (First, MI)		<input type="checkbox"/> Transfused    Date: ____/____/____    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Mother's Date of Birth		Mother's Phone # ( ) -		<input type="checkbox"/> NICU <input type="checkbox"/> Hyperal <input type="checkbox"/> Carnitine <input type="checkbox"/> Meconium ileus	
	Street (PO Box)		Newborn PCP / Practice Name		Race (check all that apply):    Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	City    State    Zip		Street (PO Box)		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	
Emergency Contact		Emergency Contact # ( ) -		Newborn PCP / Practice Name		
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		City    State    Zip		Street (PO Box)		
Mother's Medical History:    HBsAg:		PCP Phone Number ( ) -		Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed    Date: ____/____/____    Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Pos.		If not performed √ reason:		<input type="checkbox"/> refused <input type="checkbox"/> transferred <input type="checkbox"/> <24 hrs. <input type="checkbox"/> echo performed		
<input type="checkbox"/> On Steroids <input type="checkbox"/> Neg.		AFFIX ACCESSION LABEL HERE		<input type="checkbox"/> prenatal dx <input type="checkbox"/> other _____		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown						



SUBMITTER KEEP THIS COPY

Total Form Height (all parts) 4" (101.60mm)

Part 3: 14.5# Yellow CFB, black and red185 ink face only, 3/16" black press number 8 1/16" (204.8mm)

Face of Parts 4 & 5 (no copy on back)

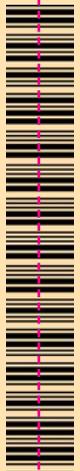
Cyan shaded area represents CF ink coverage area

Dotted Magenta lines signify perf lines.

stub: 7/16"

perf: 5/8"

PENNSYLVANIA DEPT. OF HEALTH EXPIRES 2018-06	Pennsylvania Department of Health <b>TOP COPY FOR LAB; SUBMITTER MAY KEEP YELLOW COPY</b> Newborn Screening Specimen Phone: (717) 783-8143 • TTY: (717) 783-6514		<input type="checkbox"/> Monitor for _____		SN PA151090501	
	<input type="checkbox"/> Initial Specimen <input type="checkbox"/> Repeat Specimen → Initial FP#:		<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		<input type="checkbox"/> Single Birth <input type="checkbox"/> Multiple Birth → If Multiple: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other: _____	
	Birth Facility Name ("Home" if home birth)		Birth Date    Time <input type="checkbox"/> AM <input type="checkbox"/> PM		Birth Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Submitter Name		Collection Date    Time <input type="checkbox"/> AM <input type="checkbox"/> PM		Current Wt.: _____ <input type="checkbox"/> gms. <input type="checkbox"/> lbs.oz.	
	Address if no CODE given		Weeks Gest.: _____		Medical Record #: _____	
	BABY'S Name (Last)		BABY'S Name (First)		<b>At Time of Collection:</b> Drawn By: _____	
	MOTHER'S Name (Last)		MOTHER'S Name (First, MI)		<input type="checkbox"/> Transfused    Date: ____/____/____    Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM	
	Mother's Date of Birth		Mother's Phone #		<input type="checkbox"/> NICU <input type="checkbox"/> Hyperal <input type="checkbox"/> Carnitine <input type="checkbox"/> Meconium ileus	
	Street (PO Box)		Race (check all that apply):		Hispanic?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	City    State    Zip		Newborn PCP / Practice Name		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Pac. Isl. <input type="checkbox"/> Asian <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other	
Emergency Contact		Emergency Contact #		Street (PO Box)		
Medical Assistance: <input type="checkbox"/> Yes <input type="checkbox"/> No		City    State    Zip		PCP Phone Number		
Mother's Medical History:		HBsAg:		Pulse ox: <input type="checkbox"/> passed <input type="checkbox"/> failed    Date: ____/____/____    Time ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Pos.		<input type="checkbox"/> On Steroids <input type="checkbox"/> Neg.		If not performed ↓ reason:		
<input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		AFFIX ACCESSION LABEL HERE		<input type="checkbox"/> refused <input type="checkbox"/> transferred <input type="checkbox"/> <24 hrs. <input type="checkbox"/> echo performed		
				<input type="checkbox"/> prenatal dx <input type="checkbox"/> other _____		



LOT 104568/  
 315118  
 Ahlstrom  
 PerkinElmer 226



Total Form Height  
 (all parts)  
 4" (101.60mm)

Part 4: 100# Manila Tag,  
 CF ink coverage over demographic area

black ink face only,  
 3/16" black press number,  
 Code 3 of 9 barcode with human readable, and  
 Mod 43 check digit (contained only in the barcode)  
 8 5/16" (211.13mm)

Part 5: PerkinElmer 226;  
 ID333 biologically inactive Ink face only  
 Circles = 12.7mm ID  
 1 9/16" (39.67mm)

# Back of Part 6 (no copy on front)

Dotted Magenta lines signify perf lines.

stub: 7/16"

folding flap: 1 9/16"

## INSTRUCTIONS

### Screening Instructions

The sample should be drawn by a health professional experienced in this type of collection. Specimens should be obtained between 24 and 48 hours of age.

### Sample Collection

- Sterilize the heel area with alcohol, air dry, and puncture with a sterile disposable lancet.
- Apply blood to the front side of the filter paper only.
- Completely fill each of the five circles on the filter paper with a single, free flowing drop of blood.
- Make sure the blood soaks through to the back of the filter paper.
- Do not layer successive drops.
- **The use of capillary tubes is not recommended. Do not use devices that contain EDTA, citrate, oxalate, or heparin.**

### Drying the Sample

- Air dry on a clean, flat surface for three to four hours away from heat and light.
- Do not stack, or allow the blood spots on the filter paper to touch other surfaces while drying.

### Submit to the Screening Laboratory

Newborn screening specimens should be received by the laboratory within 24 hours of collection. It is recommended that specimens be sent overnight by UPS, utilizing their ICVS system.

PKU monitoring can be shipped using postage paid USPS envelopes.

**DO NOT TOUCH BLOOD COLLECTION AREA. IT MAY CONTAMINATE RESULTS.**



COLLECT SAMPLE FROM SHADED AREA

- |       |                                     |
|-------|-------------------------------------|
| RIGHT | ACCEPTABLE                          |
|       | Circle filled and evenly saturated  |
| WRONG | UNACCEPTABLE                        |
|       | Layering                            |
|       | Insufficient, multiple applications |
|       | Serum rings present                 |

PerkinElmer Health Sciences, Inc.  
17 P and N Drive, Greenville, SC 29611 USA



AND PROTECTIVE  
FLAP IS IN PLACE  
BEFORE  
SUBMITTING  
SPECIMEN  
**PLEASE MAKE  
SURE THAT THE  
BLOOD SPOTS  
ARE COMPLETELY  
DRY**  
FOLD BACK DURING  
DRYING BUT  
**DO NOT REMOVE  
THIS COVER FLAP.  
IT IS FOR THE  
PROTECTION OF  
THE SPECIMEN  
HANDLERS.**

Total Form  
Height  
(all parts)  
4" (101.60mm)

Part 6: 28# White Ledger;  
black and red 185 ink back only  
11 3/16" (284.18mm)