

	Phone	
	Toll Free	
	Fax.	
	Form Name	New Jersey IEM-1
	Design ID	
	Version	
	Design Date	04/24/19 RC
Approved ☐ Not Approved ☐		
Signature		
Print Name		Date

Changes from previous job
1.
2.
3. Added 3/16th Black Consecutive Number to filter per customer request
4. Replaced ID333 with ID0606 ink on Part 5
5. Updated lineholes to represent actual size
6. Moved variable information from filter to the Face of Part 4
7. Removed Meconium ileus from all parts per customer request

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

Front of Form (Flap Folded)

All measurements can vary +/- 1/16" (1.6mm).
Manufacturing equivalent substitutions allowed for demographic papers
Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

Perf: 3/4"

Folded Flap: 1 1/2"

DO NOT USE THIS FORM AFTER 04/30/2022

BABY'S LAST NAME *(PRINT)*

SN 19100001

Instructions to Submitter:

After entering the newborn's name, remove this copy and give it to the parents of this newborn.

Parents,

Your baby has had his/her Newborn Screening blood test. This is an important public health service that can protect your baby. Infants may look healthy but have certain rare health problems which can be found by this test.

A small amount of blood was taken from your baby's heel and sent to the New Jersey Newborn Screening Laboratory for testing. The hospital has given you the brochure "These Tests Could Save Your Baby's Life." This brochure has more information about Newborn Screening.

Please take this notice to your baby's doctor, who can get a copy of the results by contacting the Newborn Screening Laboratory.

Por favor lleve esta carta al doctor de su bebé.

New Jersey Department of Health

<http://www.newbornscreening.nj.gov>

PARENT COPY

DO NOT REMOVE THIS COVER FLAP

It is for the protection of the specimen and the specimen handlers.

OPEN this flap to uncover the circles for blood collection **AND** leave open while drying.

BEFORE submitting the specimen:
Make sure the spots are completely dry and the protective flap is folded over the dried blood spots.

BIOHAZARD

Total Form Length (flap folded)
10" (254mm)

Total Form Height (all parts)
4" (106mm)

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Back of Part 1 (copy on face)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers

Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

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

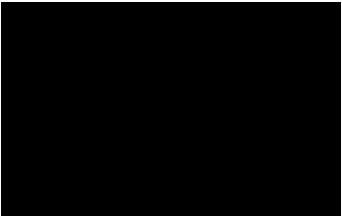
Perf: 3/4"

Your baby’s specimen will be securely stored according to Department of Health policy.
The current policy is available on the Newborn Screening Program’s website:
<http://www.newbornscreening.nj.gov>.

Newborn Screening Laboratory
New Jersey Department of Health
P.O. Box 371
Trenton, NJ 08625-0371

Total Form Height
(all parts)
4" (106mm)

Part 1: 20# Green Bond
Black and Red 185 ink face,
Black ink only on back,
3/16" Red 185 consecutive number on face,
Shaded Words & Lines = 20%,
8 1/2" (215.9mm)



Form Name	New Jersey IEM-1
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Face of Part 2 (no copy on back)

All measurements can vary +/- 1/16" (1.6mm).
Manufacturing equivalent substitutions allowed for demographic papers
Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

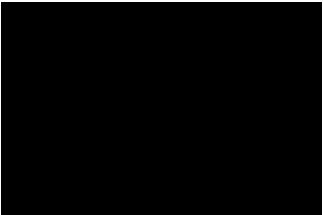
----- Dotted Magenta lines signify perf lines.

Perf: 3/4"
↔

BABY'S LAST NAME <i>(PRINT)</i>										[SN] 19100001		DO NOT WRITE IN THIS AREA!									
Birth Date			Date of Sample			Type of Feeding ☐ Breast ☐ HAL/TPN ☐ Formula ☐ Other _____			Antibiotic? ☐ Yes ☐ No		BABY'S MEDICAL RECORD NO.										
Birth Time ☐ am ☐ pm			Sample Time ☐ am ☐ pm			Multiple Birth? ☐ Yes If Yes, A, B, C, etc.: ☐ No			Remarks												
Gender ☐ M ☐ F		Birthweight gms		Transfusion PRIOR to sample collection? If Yes, give date and time : ☐ No ☐ Yes:-			Gestational Age wks			New Jersey Department of Health INITIAL NEWBORN SCREENING REQUEST 19100001 [S]											
MOTHER'S NAME (LAST, FIRST) <i>(PRINT)</i>							Mother's Age														
Address					Apt. #		Mother's Race 1 ☐ White 2 ☐ Black or African American 3 ☐ Asian		4 ☐ American Indian/ Alaskan Native 5 ☐ Native Hawaiian or Other Pacific Islander 8 ☐ Other											Mother's Hispanic Origin ☐ Yes ☐ No	
City, State, Zip											Mother's Telephone No.										
HOSPITAL NAME AND ADDRESS										BABY'S PHYSICIAN NAME AND ADDRESS											
Telephone No. _____										Telephone No. _____											
IEM-1 JAN 16 2022-04-30										SPECIMEN SUBMITTED BY: ☐ Hospital ☐ Baby's Physician H5782											
										NJDOH/NBS LAB COPY											

Total Form Height
(all parts)
4" (106mm)

Part 2: 16# White CB
Black and Red 185 ink face only,
3/16" Red 185 consecutive number,
Code 128 barcode with one human readable,
Shaded Words & Lines = 20%,
8 1/2" (215.9mm)



Form Name	New Jersey IEM-1
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Face of Parts 4 and 5 (copy on back)

All measurements can vary +/- 1/16" (1.6mm).

Manufacturing equivalent substitutions allowed for demographic papers

Glue lines are between the stubs of parts 1, 2, 3, 4, and 6 and in between parts 4 and 5.

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

Perf: 3/4"

BABY'S LAST NAME <i>(PRINT)</i>				SN	19100001	DO NOT WRITE IN THIS AREA!	
Birth Date	Date of Sample	Type of Feeding ☐ Breast ☐ HAL/TPN ☐ Formula ☐ Other _____	Antibiotic? ☐ Yes ☐ No	BABY'S MEDICAL RECORD NO.			New Jersey Department of Health INITIAL NEWBORN SCREENING REQUEST 19100001 SN Completely fill 5 circles with blood.
Birth Time ☐ am ☐ pm	Sample Time ☐ am ☐ pm	Multiple Birth? ☐ Yes If Yes, A, B, C, etc.: _____ ☐ No	Remarks				
Gender ☐ M ☐ F	Birthweight gms ☐ No ☐ Yes:-	Transfusion PRIOR to sample collection? If Yes, give date and time : _____	Gestational Age wks				
MOTHER'S NAME (LAST, FIRST) <i>(PRINT)</i>			Mother's Age				
Address		Apt. #	Mother's Race 1 ☐ White 2 ☐ Black or African American 3 ☐ Asian	4 ☐ American Indian/Alaskan Native 5 ☐ Native Hawaiian or Other Pacific Islander 8 ☐ Other	Mother's Hispanic Origin ☐ Yes ☐ No	Collector's Initials / Date: _____	
City, State, Zip		Mother's Telephone No.					
HOSPITAL NAME AND ADDRESS			BABY'S PHYSICIAN NAME AND ADDRESS				
Telephone No. _____			Telephone No. _____				
IEM-1 JAN 16 PerkinElmer 226 Ahlstrom SPECIMEN SUBMITTED BY: ☐ Hospital ☐ Baby's Physician H5782							
LOT 112147 / 30310002 2022-04-30							
NJDOH/NBS LAB COPY							

Total Form Height
(all parts)
4" (106mm)

Part 4: 33# White CF
Black and Red 185 ink face only,
3/16" Red 185 consecutive number,
Code 128 barcode with one human readable,
Shaded Words & Lines = 20%,
8 1/2" (215.9mm)

Part 5:
ID0606 ink face and
back, 3/16" Black
Consecutive Numbers
Face only, Circles are
12.7mm ID,
2" (50.8mm)

