



Ontario Newborn Screening Program

Children's Hospital of Eastern Ontario

Department of Genetics

401 Smyth, Ottawa Ont. K1H 8L1

BULLETIN #32 – October 27, 2008

Changes to Blood Dot Specimen Cards and Telehealth Webcast Reminder

1. Changes to Blood Dot Specimen Cards

The Ontario Newborn Screening Program will soon be launching an updated version of the blood dot specimen card.

Please continue to use your existing stock of the previous versions of the card but, to avoid having to discard expired stock, please check the expiry dates and use them in the order they were received. Make sure to discard any cards that are past their expiry date.

Highlights of the new card (please see the next pages for pictures):

1. Additional content in the Parent letter (which you will note is now double-sided and translated into French)
2. Reorganization of the "Infant" and "Mother/Guardian" sections
3. Gestational age is now required for *all* infants
4. Additional space for the **ordering health care provider's provider number**, which is required information under the Laboratory and Specimen Collection Centre Licensing Act. The ordering health care provider is the physician or midwife who is responsible for ensuring the baby has a newborn screen. This is not necessarily the baby's health care provider following discharge.

As you begin to use this revised version of the card, please feel free to send us your feedback.

2. Third Annual Newborn Screening Telehealth Presentations

Did you miss this year's telehealth education series?

For your convenience, the telehealth presentations of the Ontario Newborn Screening Program's third annual telehealth education series were recorded and

Additional information about the Ontario Newborn Screening Program can be found at:
www.newbornscreening.on.ca

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Shelley Kennedy or Sari Zelenietz, Genetic Counsellors
(613) 738-3222, option #1; NewbornScreening@cheo.on.ca



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are now accessible from the public archives of the Ontario Telemedicine Network website at <http://webcast.otn.ca/archives.html>. Just click on the presentation you want to see. On September 17th, Ms. Sari Zelenietz presented "Saving Lives Through Newborn Screening: We All Play A Part" (44 minutes). On September 25th, Ms. Shelley Kennedy presented "The Heelprick Test: Helpful Hints And Common Pitfalls" (43 minutes).

If you have any questions or feedback, please contact us at GeneticsEducator@cheo.on.ca.

Thank you for your cooperation and assistance in making the Ontario Newborn Screening Program the most effective and efficient that it can be.

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Programme de dépistage des nouveau-nés de l'Ontario

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401 Smyth Road, Ottawa, Ontario

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Tel: 613-738-3222

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PARENT INFORMATION SHEET

Dear Parent,

A blood sample has been taken from your baby's heel to screen for serious disorders which can cause mental retardation, poor growth, or death if not treated. The pamphlet "Newborn Screening: A healthy start leads to a healthier life" describes this test. If you have not received this pamphlet, ask your nurse, baby's physician or your midwife for a copy.

If your baby's sample is taken before he or she is 24 hours old, ask your midwife or your baby's physician to repeat the newborn screening test within 5 days.

The Ontario Newborn Screening Program will report screening results to the hospital or health care provider who sent the sample. If a repeat sample is needed, the Program will notify the health care provider who submitted the sample. If the screen is positive, you or your baby's health care provider will be contacted directly and the Program will refer your baby to a treatment centre. Personal health information will be shared between the health care providers involved in newborn screening and diagnosis to ensure your baby receives appropriate care and follow-up. You may prefer not to have this information shared, in which case, please discuss this with your health care provider or contact the Ontario Newborn Screening Program.

If you have any questions, or would like more information, please speak to your baby's doctor, your midwife, contact the Ontario Newborn Screening Program or visit our website at www.newbornscreening.on.ca.

INSTRUCTIONS TO HOSPITAL:

Remove this top sheet and give to parent.

Fill out the first copy of the requisition form.

USE BALL POINT PEN. PRESS HARD. INSTRUCTIONS ON BACK. PRINT LEGIBLY. IF A STAMP IS USED, STAMP ALL COPIES. COMPLETE ALL FIELDS.

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LETTRE AUX PARENTS

Cher Parent,

Un échantillon de sang a été prélevé du talon de votre bébé pour effectuer un test de dépistage pour des maladies qui peuvent causer de graves problèmes de santé, dont des déficiences intellectuelles, des problèmes de croissance et même la mort, si la maladie n'est pas traitée. Le pamphlet «Le dépistage des maladies chez les nouveau-nés: un départ en santé pour une vie en meilleure santé» décrit ce test. Si vous n'avez pas reçu ce pamphlet, demandez une copie à votre infirmière, le médecin ou la sage-femme de votre bébé.

Si l'échantillon a été prélevé dans les 24 premières heures après la naissance de votre bébé, demandez au fournisseur de soins de santé de votre bébé de le refaire dans les cinq jours qui suivent.

Le Programme de dépistage des maladies chez les nouveau-nés de l'Ontario enverra le rapport des résultats à l'hôpital ou au fournisseur de soins de santé qui a envoyé l'échantillon. Si un nouvel échantillon est demandé, le Programme communiquera avec le fournisseur de soins de santé qui a envoyé l'échantillon. Si le test de dépistage est positif, vous ou votre fournisseur de soins de santé sera contacté directement et le Programme demandera une consultation pour votre bébé à un centre de traitement. Afin d'assurer que votre bébé reçoive un suivi et des soins adéquats, des renseignements médicaux personnels seront partagés parmi les fournisseurs de soins de santé impliqués dans le processus du test de dépistage et du diagnostic. Il se peut que vous préférerez ne pas partager cette information. Si c'est le cas, veuillez en discuter avec votre fournisseur de soins de santé ou contactez le Programme de dépistage des maladies chez les nouveau-nés de l'Ontario.

Si vous avez des questions, parlez à votre fournisseur de soins de santé, contactez le Programme de dépistage des maladies chez les nouveau-nés de l'Ontario ou consultez notre site Internet au www.newbornscreening.on.ca.


INSTRUCTIONS POUR L'HOPITAL:

Enlever cette page de couverture et la donner au parent.
Remplir la première page de la réquisition.

USE BALL POINT PEN. PRESS HARD. INSTRUCTIONS ON BACK. PRINT LEGIBLY. IF A STAMP IS USED, STAMP ALL COPIES. COMPLETE ALL FIELDS.

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|--|---|--|---|
| NBS Barcode <small>FOR OFFICE USE ONLY</small> | |  Ontario Newborn Screening Program Children's Hospital of Eastern Ontario 401 Smyth Road, Ottawa, Ontario K1H 8L1 Tel: 613-738-3222 | |
| 1234567 | | | |
| INFANT | Last Name _____ Sex: <input type="radio"/> M <input type="radio"/> F | | Date of Birth Y Y M M D D H H M M <input type="radio"/> AM <input type="radio"/> PM |
| | First Name _____ Multiple Birth: <input type="radio"/> NA <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C | | Time of Birth Y Y M M D D |
| | Health Card Number _____ Birth Weight: _____ g | | Date of Collection H H M M <input type="radio"/> AM <input type="radio"/> PM |
| Feeding: <input type="radio"/> Breast <input type="radio"/> Formula <input type="radio"/> TPN <input type="radio"/> NPO | | Date of Collection Y Y M M D D H H M M <input type="radio"/> AM <input type="radio"/> PM | |
| Retest 1st Test <input type="radio"/> Retest Premature <input type="radio"/> Retest Prior Unsat <input type="radio"/> Retest Prior transfusion <input type="radio"/> | | Transfusion: Y <input type="radio"/> N, if yes: Y Y M M D D Gestational age: _____ wks | |
| MOTHER/GUARDIAN | Last Name _____ First Name _____ | | Adoption <input type="radio"/> Baby in CAS care <input type="radio"/> |
| | Date of Birth Y Y Y Y M M D D | | Phone Number _____ |
| | Address _____ City _____ Prov. _____ Postal Code _____ | | |
| SUBMITTING HEALTH CARE PROVIDER | Hospital/Midwifery Practice Name _____ | | |
| | Address _____ City _____ | | |
| | Prov. _____ Postal Code _____ Hospital's Phone Number _____ X | | |
| | Ordering Health Care Provider: Last Name _____ First Name _____ | | |
| License Number _____ | | <div style="border: 1px dashed black; padding: 10px; width: fit-content; margin: auto;"> Sticker </div> | |
| Submitter Unique Number _____ | | | |
| Birth Hospital (if different from above) _____ | | | |
| CC REPORT TO COMPLETE ALL FIELDS | Health Care Provider Following Discharge (Last Name, First Name) _____ | | |
| | Address _____ | | |
| | City _____ Prov. _____ | | |
| | Postal Code _____ Phone Number _____ X | | |
| Report: <input type="checkbox"/> Screen Negative <input type="checkbox"/> Screen Positive | | | |
| USE BALL POINT PEN. PRESS HARD. INSTRUCTIONS ON BACK. PRINT LEGIBLY. IF A STAMP IS USED, STAMP ALL COPIES. COMPLETE ALL FIELDS. | | | |

Reorganization of demographic information

Gestational age required for all infants

Reorganization of demographic information

Provider number required for ordering physician/midwife

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