



Ontario Newborn Screening Program

Children's Hospital of Eastern Ontario

Department of Genetics

401 Smyth, Ottawa Ont. K1H 8L1

BULLETIN #32 Addendum – October 28, 2008

Changes to Blood Dot Specimen Cards

1. Changes to Blood Dot Specimen Cards

It has come to our attention (thanks to our many vigilant readers) that we mistakenly sent out an incorrect PDF of the new version of the newborn screening card that said “license number” instead of “provider number.” We apologize for this confusing error.

To clarify, we are requesting only the **provider number**. This is the ministry assigned physician's (OHIP billing) provider number or the midwife's provider number. Please see the correct version of the new card attached.

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

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

These bulletins are being circulated to keep you abreast of changes to the Ontario Newborn Screening program. Please share this information with any relevant personnel in your hospital / clinic. If there is someone who would like to be added to this list, contact:
Shelley Kennedy or Sari Zelenietz, Genetic Counsellors
(613) 738-3222, option #1; NewbornScreening@cheo.on.ca



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NBS Barcode <small>FOR OFFICE USE ONLY</small>		Ontario Newborn Screening Program Programme de dépistage des nouveaux-nés de l'Ontario A123456 Children's Hospital of Eastern Ontario 401 Smyth Road, Ottawa, Ontario K1H 8L1 Tel: 613-738-3222	
INFANT	Last Name _____ Sex: <input type="radio"/> M <input type="radio"/> F First Name _____ Multiple Birth: <input type="radio"/> N/A <input type="radio"/> A <input type="radio"/> B <input type="radio"/> C Health Card Number _____ Birth Weight: _____ g Feeding: <input type="radio"/> Breast <input type="radio"/> Formula <input type="radio"/> 1st Test <input type="radio"/> Retest Premature <input type="radio"/> TPN <input type="radio"/> NPO <input type="radio"/> Retest Prior Unsat <input type="radio"/> Retest Prior transfusion Transfusion: <input type="radio"/> Y <input type="radio"/> N, if yes: _____ Gestational age: _____ wks		Date of Birth _____ H H M M <input type="radio"/> AM <input type="radio"/> PM Time of Birth _____ Y Y M M D D Date of Collection _____ H H M M <input type="radio"/> AM <input type="radio"/> PM Time of Collection _____
	Last Name _____ First Name _____ Y Y Y Y M M D D _____ <input type="radio"/> Adoption Date of Birth _____ Phone Number _____ <input type="radio"/> Baby in CAS care Address _____ City _____ Prov. _____ Postal Code _____		
MOTHER/GUARDIAN	Hospital/Midwifery Practice Name _____ Address _____ City _____ Prov. _____ Postal Code _____ Hospital's Phone Number _____ X Ordering Health Care Provider: Last Name _____ First Name _____ Provider Number _____ ← Provider number requested Submitter Unique Number _____ Birth Hospital (if different from above) _____		FOR OFFICE USE ONLY Screen Negative <input type="checkbox"/> Screen Positive <input type="checkbox"/> Report: <input type="checkbox"/> Screen Positive <input type="checkbox"/> Screen Negative
	Health Care Provider Following Discharge (Last Name, First Name) _____ Address _____ City _____ Prov. _____ Postal Code _____ Phone Number _____ X		
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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