



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 FOR OFFICE USE ONLY		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: ☐ M ☐ F	Date of Birth
	First Name	Multiple Birth: ☐ N/A ☐ A ☐ B ☐ C	Time of Birth
	Health Card Number	Birth Weight: g	Date of Collection
	Feeding: ☐ Breast ☐ Formula ☐ TPN ☐ NPO	Transfusion: ☐ Y ☐ N, if yes:	Time of Collection
MOTHER/GUARDIAN			
Last Name		First Name	☐ Adoption ☐ Baby in CAS care
Date of Birth		Phone Number	
Address			
City		Prov.	Postal Code
SUBMITTING HEALTH CARE PROVIDER			
Hospital/Midwifery Practice Name		City	
Address		Prov.	Postal Code
Hospital's Phone Number		X	
Ordering Health Care Provider: Last Name		First Name	
Provider Number		Sticker	
Submitter Unique Number			
Birth Hospital (if different from above)			
CC REPORT TO COMPLETE ADDRESS REQUIRED			
Health Care Provider Following Discharge (Last Name, First Name)			
Address			
City		Prov.	
Postal Code		Phone Number	X
Report: ☐ Screen Positive ☐ Screen Negative			

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

Provider number requested

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