

# Screening calendar for all babies admitted to hospital

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

**Day 0:**  
**Date of birth**

Take pre  
transfusion  
blood spot



**Day 1**

**Day 2**

**Day 3**

**Day 4**

**Day 5**

Take 4 spot  
sample  
**ALL** babies  
must have a  
sample sent  
by day 8



**Day 6**

**Day 7**

**Day 8**

**Day 9**

**Day 10**

Pre-transfusion: Day 0-4  
babies admitted to hospital <5 days.  
Mark card 'pre transfusion' in the  
comments box

**Day 11**

**Day 12**

**Day 13**

**Day 14**

**Day 15**

**Day 16**

**Day 17**

Day 5-8: Use a separate card for pre  
transfusion and day 5-8 sample.

**Day 18**

**Day 19**

**Day 20**

**Day 21**

**Day 22**

**Day 23**

**Day 24**

**Day 25**

**Day 26**

**Day 27**

**Day 28**

**Day 29**

# Screening calendar for babies born at less than 32 weeks gestation

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

**Day 0:**  
**Date of birth**

Take pre  
transfusion  
blood spot



**Day 1**

**Day 2**

**Day 3**

**Day 4**

**Day 5**

Take 4 spot  
sample  
**ALL** babies  
must have a  
sample sent  
by day 8



**Day 6**

**Day 7**

**Day 8**

**Day 9**

**Day 10**

Pre-transfusion: Day 0-4  
babies admitted to hospital <5 days.  
Mark card 'pre transfusion' in the  
comments box

**Day 11**

**Day 12**

**Day 13**

**Day 14**

**Day 15**

**Day 16**

**Day 17**

Day 5-8: Use a separate screening  
card for each sample

**Day 18**

**Day 19**

**Day 20**

**Day 21**

**Day 22**

**Day 23**

**Day 24**

Day 28: If born <32 weeks gestation  
take a 2 spot sample at 28 days or  
day of discharge whichever is sooner  
and mark 'CHT preterm' in the  
comments box

**Day 25**

**Day 26**

**Day 27**

**Day 28**

Take 2 spot  
pre term  
sample as  
born at  
<32 weeks  
gestation



**Day 29**

# Screening calendar example for babies who have been transfused

Sunday

Monday

Tuesday

Wednesday

Thursday

Friday

Saturday

**Day 0:**  
**Date of birth**

Take pre  
transfusion  
blood spot



**Day 1**

**Day 2**

**Day 3**

**Day 4**

Baby given  
red cells

**Day 5**

**Day 6**

Baby given  
platelets

**Day 7**

**Day 8**

Take 4 spot  
sample as  
**ALL** babies  
must have a  
sample sent  
by day 8



**Day 9**

**Day 10**

Take repeat  
4 spot  
sample as  
the baby is  
now a full  
3 days post  
transfusion



**Day 11**

**Day 12**

**Day 13**

**Day 14**

**Day 15**

**Day 16**

**Day 17**

**Day 18**

**Day 19**

**Day 20**

**Day 21**

**Day 22**

**Day 23**

**Day 24**

**Day 25**

**Day 26**

**Day 27**

**Day 28**

**Day 29**


Pre-transfusion: Day 0-4  
babies admitted to hospital <5 days.  
Mark card 'pre transfusion' in the  
comments box

Day 5-8: use separate card for each  
sample, please include details of  
transfusions.

Repeat: Post transfusion

# Newborn blood spot screening card information


NEWBORN SCREENING BLOOD SPOT TEST														
Baby's NHS No. <span style="border: 1px solid black; padding: 2px;">  </span>														
SURNAME										DATE OF SPECIMEN <span style="border: 1px solid black; padding: 2px;">D D M M Y Y</span>				
FORENAMES										Is this a repeat (✓) <span style="border: 1px solid black; padding: 2px;">YES NO</span>				
HOME ADDRESS										Has baby had a blood transfusion (✓) <span style="border: 1px solid black; padding: 2px;">YES NO</span>				
Please Affix Label on Every Page										BABY'S D.O.B. <span style="border: 1px solid black; padding: 2px;">D D M M Y Y</span>				
										If yes, date of last transfusion <span style="border: 1px solid black; padding: 2px;">D D M M Y Y</span>				
POSTCODE										Is the baby in hospital (✓) <span style="border: 1px solid black; padding: 2px;">YES NO</span>				
SEX (✓) M F										If yes, current hospital and ward:				
G.P. PRACTICE NAME					MOTHER'S FULL NAME					BIRTH WEIGHT (g)				
G.P. ADDRESS					MOTHER'S DOB					COMMENTS (Family history e.g. Mother's carrier status (Antenatal HBO code, HBO Outcome code); temporary address)				
G.P. PRACTICE CODE					MOTHER'S NHS NUMBER									
PCT					PARENT TELEPHONE NUMBER									
HOSPITAL OF BIRTH					ALTERNATIVE SURNAME									
TEL. NO. OF PERSON TAKING SAMPLE					NAME OF PERSON TAKING SAMPLE (PRINT)									





SN 0903195380


SN 0903195380

Expiry Date: 12-2014

1 

2 

3 

4 

**Zero tolerance Info:** NHS number, D.O.B, date of sample: If any of this information is not on the card or is incorrect it will be rejected and a repeat will be requested. It is the responsibility of the person completing the card to find this info so screening isn't delayed.

**Routine Info:** This information should be easily available for each patient, if any of this information is missing the card will not be rejected, but the labs will have to contact the ward to chase up the information. This could delay screening. Please include details of transfusions, this info is essential to ensure accurate screening.

**Non-essential info:** Mums NHS number etc. If this information is missing the card will still be screened so don't delay screening to obtain this information, but if you have it please include it.

**Please check screening card expiry date.**