ANNUAL NEWBORN SCREENING (NBS) REPORT CARD/EDUCATIONAL NEEDS ASSESSMENT

OKLAHOMA State Department of Health | Newborn Screening Program

Hospital Name: _____ Year _____

SECTION 1 – Annual Performance Report Card

BLOODSPOT:		
Unsatisfactory Specimen Percentage	(Benchmark <2%)	*
Annual Transit Time Percentage	(Benchmark >95%)	*
Initial Screen Birth to Collection Time between 24-48 hrs Percentage	(Benchmark >95%)	
Abnormal Specimen Summary for:		
Presumptive Positive Result An out-of-range screening test result that is used to indicate high-risk/possible disease		
Borderline result A slightly out-of-range result that is used to indicate low risk for disease		
Probable Hemoglobin Traits A trait condition indicates that the infant is a carrier for the identified hemoglobin disorder		
Number of babies diagnosed with a NBS disorder at the time of report (Not all babies may have completed diagnostic testing)		
Number of NBS specimens submitted with missing demographic information		
Missing Date of Collection		
Missing Time of Collection		
Missing Other (submitter ID, date of birth, gestational age, birth weight)		
*These items are indicators affecting need for hospital site visit for process evaluation/improvement.		

HEARING:		
Results not reported within 7 days of screen completion percentage	(Benchmark < 2%)	*
Hearing screens not performed prior to discharge **Note:** Does not include refusals, expired, or not screened due to medical constraints.	(Benchmark 0)	*
Average refer rate: **Note:** The Joint Committee on Infant Hearing (JCIH) indicates NBHS programs should have a refer rate between 1-4%		
Number of babies diagnosed with a permanent hearing loss in one or both ears (Not all babies may have completed diagnostic testing at the time of report)		
Number of hearing screening results reported with missing information		
Missing results for one ear		
Missing screen date or incorrect date		
*These items are indicators affecting need for hospital site visit for process evaluation/improvement.		

CCHD:	
Number of babies with CCHD screen results not reported	

(see page 2 for Educational Needs/Wants Assessment – please complete and return to NBS Program)

Hospital Name: _____ Year _____

SECTION 2 – EDUCATIONAL NEEDS/WANTS

FOR NBS PROGRAM COMPLETION	
	Site visit recommended by NBS program based on performance metrics noted on report above
FOR HOSPITAL STAFF COMPLETION – PLEASE CHECK ALL THAT APPLY AND RETURN BY EMAIL TO NEWBORNSCREEN@HEALTH.OK.GOV	
	Site visit requested by facility
	Staff training
	Meet with leadership
Specific educational requests:	

SECTION 3 - CONTACT INFORMATION REFRESH

PLEASE PROVIDE ADDITIONS, CORRECTIONS WHERE NEEDED:

NEWBORN SCREENING

Oklahoma State Department of Health
Newborn Screening Program
Follow-Up Phone: 405-426-8310
Follow-Up Fax: 405-900-7556
Newbornscreen@health.ok.gov