NEWBORN SCREENING ONTARIO
DÉPISTAGE NÉONATAL ONTARIO

NSO is located at
CHEO

# PARENT/GUARDIAN REQUEST FOR RELEASE OR DESTRUCTION OF NEWBORN SCREENING BLOOD SPOT CARD(S)

**Please complete this form and print clearly.**

## 1. Patient Information

- Child's Name at birth:_____
- Date of Birth (dd/mm/yyyy): ____/___/_____
- Health Card Number:_____
- Mother's Name (at time of child's birth): _____

## 2. Authorization for Release/Destruction of Blood Spot Card(s):

### I. Parent/Guardian Information:

☐ Check here if you are the sole guardian for the child indicated above

_____ _____
Last name First name

_____ _____ _____
Signature Date (dd/mm/yyyy) Location

☐ **I warrant that the above information is true and accurate.**

### II. Additional Parent/Guardian Information:

_____ _____
Last name First name

_____ _____ _____
Signature Date (dd/mm/yyyy) Location

☐ **I warrant that the above information is true and accurate.**

### III. Primary Care Provider Attestation:

This form must be signed by your Primary Care Provider who can attest to your identity and guardianship of the child.

I, _____ (first and last name) have reviewed this information and confirm to the best of my knowledge that the above parents/guardians identities have been validated and are the parents/guardians of the child in question.

Signed: _____Dated: _____

## IV. Request:

☐ **I/We wish to have our child's newborn screening blood spot card(s) DESTROYED**
☐ **I/We wish to have our child's newborn screening blood spot card(s) RELEASED TO US**

Parent/Guardian Initial: _____

Additional Parent/Guardian Initial: _____

Primary Care Provider Initial: _____

**NSO recommends that samples are stored until a child is five years of age. If your child is under the age of five and you still wish destruction or release of the sample(s), this request will be honoured.**

Parent/Guardian Initial: _____

Additional Parent/Guardian Initial: _____

Primary Care Provider Initial: _____

## 3. Parent/Guardian Address and Contact Information

(Address to which blood dot card(s) will be sent OR confirmation of sample destruction will be sent)

| Street Number | Street name | Unit number |
|---|---|---|
| City | Province | Postal Code |
| Phone Number | | |

## FOR NSO USE ONLY

**I. Specimen Information:**

| | Accession Number | Date of Collection (dd/mm/yyyy) | Submitting Hospital / Midwifery Practice / HCP |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**II. Specimen barcode(s) confirmed by:**

| Signature | Print Name | Date(dd/mm/yyyy) |
|---|---|---|

**The above specimen(s) was/were:** □ **Released** □ **Destroyed by:**

| Signature | Print Name | Date(dd/mm/yyyy) |
|---|---|---|

**III. Approval provided by (*specimen destruction or release requires the approval of the Executive Director):**

| Signature | Print Name | Date(dd/mm/yyyy) |
|---|---|---|