NEWBORN SCREENING ONTARIO
DÉPISTAGE NÉONATAL ONTARIO

Newborn Screening Results Request Form

For the privacy and protection of this child, this form **must** be completed by the child's parent, guardian, or health care provider.
Results will be released to the health care provider you list below.

We strive to fulfill all requests for results within 48 hours.

Who is completing this form? Name: * _____ Phone Number: * _____

- ☐ I am this child's Health Care Provider
- ☐ I am this child's parent and a legal guardian
- ☐ I am this child's legal guardian (I will mail this form to NSO with the completed Proof of Guardianship Form)

Fields marked with a * are mandatory.

Child's Information

LAST NAME : * _____
FIRST NAME : * _____
DOB : (YYYY/MM/DD) * ☐ F * ☐ M * _____/_____/_____
ADDRESS : * _____
CITY : * _____
POSTAL CODE : * _____
PHONE : * _____
OHIP / HEALTH CARD # : * _____
BIRTH HOSPITAL : _____
Newborn Screen Form Number: _____

Mother's Information

LAST NAME : * _____
FIRST NAME : * _____
DOB (YYYY/MM/DD) : * _____/_____/_____
MOTHER'S ADDRESS at TIME of CHILD'S BIRTH : * ☐ Same as above _____
CITY : * _____
POSTAL CODE : * _____
OHIP# : _____

Child's Health Care Provider

NAME : * _____
PHONE : * _____
FAX : * _____
INSTITUTE/PRACTICE: _____
ADDRESS : * _____
CITY : * _____
POSTAL CODE : * _____
CPSO / College # : _____
Is this where this child gets his/her routine health care? ☐ Y ☐ N ☐ Unsure

Please return completed form to NSO:

By MAIL: Newborn Screening Ontario
415 Smyth Road
Ottawa, ON, K1H 8M8

By FAX: 613-738-0853

Questions?

Call NSO : 1-877-NBS-8330 (1-877-627-8330)
(613) 738-3222
Website : www.newbornscreening.on.ca
Email: newbornscreening@cheo.on.ca