NEWBORN SCREENING ONTARIO
DÉPISTAGE NÉONATAL ONTARIO

Requisition for Testing of a Residual Dried Blood Sample

Patient Information

Last Name: _____

First Name: _____

Date of Birth (yyyy/mm/dd): _____

Sex: ☐ Male ☐ Female ☐ Ambiguous

Mother's Name: _____

Address: _____

City: _____ Prov: _____

Postal Code: _____ Country: _____

Health Card #: _____

Issuing Province: _____

Ordering Health Care Provider

Name: _____

Institution: _____

Address: _____

City: _____ Prov: _____

Postal Code: _____ Country: _____

Phone: _____ Ext: _____

Fax: _____

Consent (MANDATORY)

Initial to the right to confirm that patient or guardian consents to the use of the residual screening sample for the requested testing.	

Test Request	Clinical History/Comments
☐ Cytomegalovirus (CMV) ☐ Other (please specify):	
Other/notes:	**NSO Lab Accession #** (if available)