Nemours. Alfred I. duPont Hospital for Children

Newborn Screening Program
302-651-5079
Fax: 302-295-0719

PARENT REFUSAL OF STORAGE OF BLOOD SPOT AFTER COMPLETION OF TESTING

By signing this form, I understand that I am choosing NOT to have my child's blood spot saved in the newborn screening laboratory.

I understand that blood spots are saved for use in laboratory quality management programs and in implementing laboratory procedures for new disorders that might be added to the panel of disorders screened for.

I understand that no research can be performed on saved spots without parental consent.

Name of child: ______________________________ Birth date: _____________

Hospital or place of birth: ____

Parent or guardian signature: ____

Parent or guardian printed name: _______________________________________

Relationship to child: __________________________ Date: _________________

Street address: ____

City: ____________________ State: _____ Zip: ________ Phone: ___________

Send completed form to: Nemours Newborn Screening Program
1600 Rockland Road
Wilmington, DE 19803

Fax: 302-295-0719
Phone: 302-651-5079