Supplemental Newborn Screening

Information for Physicians and Their Staff

Back of Newborn Supplemental Screening card

Place PATIENT / BABY'S hospital informational label here
OR
Fill in information below

Baby's Name: ____________

Date of Birth: ____________

CONSENT FOR NEWBORN SUPPLEMENTAL SCREENING

I am the parent or legally authorized representative of the minor patient named on the screening card accompanying this form. I understand that by signing below, I am requesting the Institute of Metabolic Disease - Baylor University Medical Center (Baylor) to conduct a screening of the patient's blood for approximately 30 inheritable metabolic diseases. I acknowledge that the screening may not detect the existence of a disease even though the disease is present, which is known as a false negative result. I acknowledge that the screening may detect the existence of a disease when in fact the disease is not present, known as a false positive result. I understand that improper handling of the screening card prior to Baylor receiving it could cause inaccurate results. I also understand that there is a possibility that the patient could suffer injury, including death, if a disease is not detected by the screening or while awaiting the results of the screening. I acknowledge and agree that I have read this consent form and understand it and that any questions I have about the screening process have been fully answered. I understand that I may contact Baylor at the address listed below if I have additional questions. I understand that the screening is voluntary, and I hereby consent to and authorize Baylor to conduct the screening on the patient.

Parent/Legal Representative Signature ____________ Witness Signature ____________

Printed Name ____________ Date ____________

BAYLOR University Medical Center at Dallas
Kimberly H. Courtwright and Joseph W. Summers Institute of Metabolic Disease

3812 Elm Street, Dallas, Texas 75226
BaylorHealth.com/newbornscreening

THE FOLLOWING INFORMATION MUST BE PROVIDED ON THE SCREENING CARD IN ORDER TO PROCESS THIS SCREENING REQUEST

- Patient's Name
- Date of Birth
- Date of Sample
- Physician Signature (if you are not a contracted facility)
- Mailing address, telephone and fax number of ordering physician or facility
- Parent/Legal Representative signature on consent form
- Witness signature on consent form

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