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, health care provider, or submitting laboratory. Results will be released to the health care provider you list below. **We are not able to send results to health care providers outside of Canada; for these requests we recommend contacting the birth hospital or midwifery practice for a baby's complete medical records. Fields marked with a * are mandatory.**

Who is completing this form? Name: * ___________________________ Phone Number: * _______________

Role: *
- ☐ 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)
- ☐ I am this child's health care provider (please select the reason for your request):
- ☐ Submitting laboratory

Reason: *
- ☐ Medical record documentation (e.g. confirmation that the infant was screened)
- ☐ The infant is not well and I am concerned they may be symptomatic of a disease targeted by newborn screening
- ☐ The infant is at risk for a disease targeted by newborn screening (e.g. family history of the disease)

Results requests for documentation purposes will be fulfilled within 14 days. We continue to recommend OLIS as the most efficient way to access results: https://ehealthontario.on.ca/en/standards/ontario-laboratories-information-system-standard

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