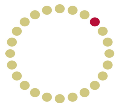

Sickle Cell Carrier Results Request Form

Please complete this form to request a child's hemoglobinopathy carrier result from newborn screening.

Fields marked with a * are mandatory.

For the privacy and protection of this child, this form **must be completed by the child's Health Care Provider or** the child's mother (the mother is the only guardian known to NSO as her name is sent to us with the newborn screening sample). If another legal guardian is requesting these results, please mail the completed form with proof of guardianship to NSO. **Results will be released to the Health Care Provider listed below.**

Child's Information

LAST NAME : * ____________________ FIRST NAME : * ____________________ DOB : (YYYY/MM/DD) * _____/_____/_____ ☐ Female * ☐ Male *

ADDRESS : * ____________________ CITY : * ____________________ POSTAL CODE : * ____________

PHONE : * ____________________ OHIP / HEALTH CARD # : * ____________________ BIRTH HOSPITAL : * ____________________

Is this child from a high-risk group? ** ☐ Yes ☐ No

** Anyone can be a carrier of a hemoglobinopathy but it is more common in people from Africa, the Mediterranean, Caribbean, Middle East, South East Asia, Western Pacific Region, South America, and Central America.

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

☐ Child does not have a Health Care Provider

NAME : * ____________________ PHONE : * ____________________ FAX : * ____________________

OFFICE ADDRESS : * ____________________ CITY : * ____________________ POSTAL CODE : * ____________

CPSO / College # : ____________________

Is this where this child gets his/her routine health care? ☐ Yes ☐ No ☐ Unsure

Type of Provider : * ☐ Family Physician ☐ Paediatrician ☐ Midwife ☐ Nurse Practitioner ☐ Other ____________

In what language would you like the results? * ☐ French ☐ English

Who is completing this form? *

☐ I am this child's mother and a legal guardian ☐ Other (please print completed form and mail with proof of guardianship)

☐ I am this child's Health Care Provider and the parent/guardian has requested this information

Additional Questions For Parents (optional) :

How did you find out you can request these results? ____________________

What language(s) do you speak at home? ____________________

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