

Newborn Screening Results Request Form

For the privacy and protection of this child, this form must be completed by the child's parent, guardian, or health care provider. 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):

- 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) * <input type="checkbox"/> F * <input type="checkbox"/> 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 : * <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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