NEWBORN SCREENING LABORATORY
BC Children's Hospital
4480 Oak Street, Room 2F27
Vancouver, BC V6H 3V4
Ph:(604) 875-2148 ; Fax: (604) 875-3836

Provincial Health Services Authority

PLEASE READ CAREFULLY AS THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS.

Directive to Destroy Leftover Newborn Screening Blood Samples

Details of blood sample (so correct card is identified):

Baby's name: _____ Mother's name: _____

Baby's date of birth: _____ Baby's hospital/place of birth: _____

Baby's Personal Health Number (PHN): Mother's PHN:

_____ _____

Details of requestor:

Both parents must sign to have the card released unless they attest to being the only parent/legal guardian.

We/I, _____ and _____, parents or legal guardians of the baby described above, hereby request the BC Newborn Screening Program to destroy our/my baby's newborn screening blood spot card. We understand that newborn screening blood spot cards are typically stored by the BC Newborn Screening Program and would be available in the future for any further health-related testing that might be deemed necessary for our child. For example, the ability to diagnose if a disease is congenital or acquired after birth may be limited.

We/I also hereby release the BC Newborn Screening Program, the Provincial Health Services Authority and any of its employees, officers, directors and physicians from any liability whatsoever for destroying this card and for the consequences of not having it available for my/our child's care in the future. (note the card will be autoclaved as blood is considered a biohazard)

Date: _____

Name (mother/legal guardian): _____ Witness name: _____

Signature (mother/legal guardian): _____ Witness signature: _____

Date: _____

Name (father/legal guardian): _____ Witness name: _____

Signature (father/legal guardian): _____ Witness signature: _____

If one parent/legal guardian:
I am the only parent/legal guardian of the baby described above.

Parent/Legal Guardian's signature: _____

Proof of identify MUST be supplied (photocopies only):

1. Baby's birth certificate; **AND**
2. Parent(s) passport photo page or drivers license; **AND**
3. If legal guardian, provide proof of guardianship.

Please return form, with photocopies of proof of identity to:
NEWBORN SCREENING LABORATORY
BC Children's Hospital, Department of Pathology
4480 Oak Street, Room 2F27, Vancouver, BC V6H 3V4

For each blood spot card, we will:

1. Separate the filter paper containing the blood spots from the blood spot card.
2. Destroy the filter paper and blood spots.
3. Notify you after the blood spots and filter paper have been destroyed, and the date destroyed.
4. File the remaining requisition, your original written request and, a copy of our letter to you.

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Release of Leftover Newborn Screening Card

Details of blood sample (so correct card is identified):

Baby's name: _____ Mother's name: _____

Baby's date of birth: _____ Baby's hospital/place of birth: _____

Baby's Personal Health Number (PHN): _____ Mother's PHN: _____

Details of requestor:

Both parents must sign to have the card released unless they attest to being the only parent/legal guardian.

We/I, _____ and _____, parents or legal guardians of the baby described above, hereby request the BC Newborn Screening Program to return our/my baby's newborn screening blood spot card. We understand that newborn screening blood spot cards are typically stored by the BC Newborn Screening Program and would be available in the future for any further health-related testing that might be deemed necessary.

We/I also hereby release the BC Newborn Screening Program, the Provincial Health Services Authority, and any of its employees, officers, directors and physicians from any liability whatsoever for the consequences of not having this card available. (Note the card will be autoclaved as blood is considered a biohazard).

Date: _____

Name (mother/legal guardian): _____ Witness name: _____

Signature (mother/legal guardian): _____ Witness signature: _____

Date: _____

Name (father/legal guardian): _____ Witness name: _____

Signature (father/legal guardian): _____ Witness signature: _____

If one parent/legal guardian:

I am the only parent/legal guardian of the baby described above.

Parent/Legal Guardian's signature: _____

Proof of identify MUST be supplied (photocopies only):

1. Baby's birth certificate; AND
2. Parent(s) passport photo page or drivers license; AND
3. If legal guardian, provide proof of guardianship.

Please return form, with photocopies of proof of identity to:
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BC Children's Hospital, Department of Pathology
4480 Oak Street, Room 2F27, Vancouver, BC V6H 3V4

Please also bring your proof of identity with you to the BC Children's Hospital Newborn Screening Laboratory when you come to retrieve the card (the lab will contact you when it is ready for pickup).

Please note the card will be heat treated (autoclaved) prior to returning to remove any potential biohazard from the dried blood spots. As a result the card will no longer be useable for biological testing.