Guthrie Test Consent Form

Patient Information

Name:

_____

Date of Birth:

_____

ID Number:

_____

Parent/Guardian Information

Name:

_____

Relationship:

_____

Contact Number:

_____

Consent

I hereby give consent for the Guthrie test (Newborn Screening) to be performed. I have been informed about the purpose, method, and possible results of the test. I understand that my/my child's information will be kept confidential.

Signature:

_____

Date:

_____

Healthcare Provider Name:

_____

To be filled by the responsible healthcare provider.