Severe Combined Immunodeficiency (SCID) Screening Consent

Patient Information

Patient Name:

Date of Birth:

Medical Record Number:

Parent/Guardian Information

Name:

Relationship to Patient:

Consent

I understand that SCID (Severe Combined Immunodeficiency) is a rare genetic disorder affecting the immune system. Screening for SCID is performed using a blood sample to detect the condition early.

I have been informed about the purpose, potential risks, and benefits of this screening. My questions have been answered.

Parent/Guardian Signature:

Date: