

Scottish Newborn Screening Laboratory
Laboratory Medicine Building Level 2B
QEUEH G51 4TF
0141 354 9277

Please email to: ggc.newbornscreeninglaboratory@nhs.scot

Consent form for the retrieval and use of the residual dried bloodspot specimen

Please fill in the details below as discussed with your clinician/healthcare professional;

CHILD'S NAME

CHILD'S CHI NUMBER IF KNOWN.....

CHILD'S DATE OF BIRTH.....

CHILD'S PLACE OF BIRTH.....

MOTHER'S NAME WHEN CHILD WAS BORN

MOTHER'S DATE OF BIRTH.....

HOME ADDRESS WHEN CHILD WAS BORN

.....

.....

I/we give permission for you to release the blood spot specimen from the above child for laboratory

investigations for

.....

NAME OF PARENT(S).....

PARENTAL SIGNATURE(S).....

DATE SIGNED.....