NATIONAL NEWBORN BLOODSPOT SCREENING PROGRAMME

OPT-OUT FORM

Baby's Unique Perinatal Identifier (UPI): ___ - ___ **Gender:** *(Please circle)* M F

Baby's Surname: **Gest Age:** *(Weeks)*

Baby's First Name: **Rank:**

Baby's Address: **Hospital/Birth Place**

Mother's Surname:

Time of Birth: H H M M **Date of Birth:** D D M M Y Y **Birth Weight *(kgs):*** .

RBC Transfusion Received? Y / N (If Yes) **Date of First Transfusion:** D D M M Y Y **Time of First Transfusion:** H H M M

Date of First Feed: D D M M Y Y **Local Health Office:**

- I _____, being the parent/legal guardian of Baby _____ does not consent to allow the Newborn Bloodspot Screen (Heel-Prick) to be carried out on my baby.
- I have read the Newborn Bloodspot Screening information leaflet and the importance of screening has also been explained to me.
- I fully understand the importance of the decision that I am taking by not allowing my baby to be screened.
- I understand that not detecting or treating one of the conditions, should my baby have one, may result in severe intellectual or physical disability which could require long term care or result in premature death.
- Reason for opt-out: _____

Signed (Parent/Legal Guardian): _____

Full Name (PRINT): _____ **Date:** _____

Signed by potential sample taker: _____ **Date:** _____

Position/Job Title: _____ **Health Area Office:** _____

Ensure copies of opt-out form are sent to all locations below

Six copies of this completed form, signed by parent/legal guardian and sample taker should be made.

A copy to be given to the parent/legal guardian and a copy kept by the sample taker, plus a copy posted/emailed to each of the following:- • The Director of Nursing/Midwifery • Director of Public Health Nursing • National Newborn Bloodspot Screening Laboratory • The baby's General Practitioner

	Director of Nursing/Midwifery	Director of Public Health Nursing	National Newborn Bloodspot Screening Laboratory (NNBSL)	General Practitioner
Name				
Address			NNBSL, Children's University Hospital, Temple Street, Dublin D01 YC67	
Date Sent				

Signed *(Potential Sample taker)*: _____ Date: _____

Name (*Block Capitals)*: _____

Parents/Legal Guardians may change their mind and 'opt back in' to have their baby screened, until their baby reaches one year of age, but it is their responsibility to inform their GP or Public Health Nurse. The Cystic Fibrosis newborn screen is not suitable if a baby is over six weeks of age and a different screen is necessary.