Department of Health and Human Services
Maine Center for Disease Control and Prevention
Children with Special Health Needs
Maine Newborn Bloodspot Screening Program
286 Water Street, Augusta, Maine 04333-0011
Tel.: (207) 287-8188; Fax: (207) 287-4743
TTY Users: Dial 711 (Maine Relay)

Request for Retrieval of Newborn Filter Paper Specimen for Additional Testing

I request that the New England Newborn Screening Program (NENSP) retrieve part of the residual dried bloodspot specimen (if available) drawn from the newborn listed below:

Infant Name:_____ DOB: _____

Hospital of Birth: _____ Mother's Name: _____

Please note:

- The additional testing of the retrieved filter paper specimen has the potential to aid in establishing a diagnosis and/or have a direct benefit for the person from whom the filter paper blood sample was taken.
- Other specimens (e.g., current blood or urine specimen) or procedures are either not obtainable or would not yield the beneficial information expected from the newborn filter paper specimen.
- Additional testing costs will be the responsibility of the consenting parent/guardian.

I assure that all the following are true (place check in box):

☐ I have permission from the parent/guardian for retrieval of the newborn specimen for additional testing.
☐ I understand that some analytes may not be stable in the stored dried blood specimen, and that there may not be enough residual specimen for the requested testing.
☐ I have made arrangements with the Maine lab that will be accepting and processing the residual dried blood specimen retrieved from the New England Newborn Bloodspot storage facility.

Signature of Medical Professional: _____ Date: _____

Printed Name and Title of Medical Professional: _____

Address: _____

Phone:_____ Fax: _____

Signature of Parent/Guardian (verbal consent is acceptable): _____

Printed Name of Parent/Guardian: _____

The specimen should be sent to the following Maine lab affiliated with my practice:

Lab Name: _____ Attn: _____

Address: _____

Phone:_____ Fax: _____

For informational purposes only: Planned testing _____

FAX FORM TO: ME NEWBORN BLOODSPOT SCREENING PROGRAM (f) 207-287-4743

To be completed by ME Newborn Bloodspot Screening Program (MNBSP)	
Date Request Received:	Signature of Staff:
Accession #:	Date of Specimen Collection: