英語

Screening Facility Copy

Expanded Newborn Screening Application & Consent Form (Free)

To: Okayama Expanded Newborn Screening Promotion Association
The Governor of Okayama Prefecture, the Mayor of Okayama City

I have read the "Expanded Newborn Screening Explanation", and having understood the screening (for SMA, SCID, BCD), I would like to apply.

I agree to the use of the blood sample collected for the "Congenital Metabolic Disorder Screening" for these tests.

Additionally, I agree to the provision of data acquired from the screening (for SMA, SCID) to the Children and Families Agency, as well as to the Children and Families Agency Research Group.

Date	YYYY / MM / DD
Applicant's Name (Parent/Guardian)	
Name of Baby's Mother	In case of multiple births, please write the number indicating the baby's order of birth after the mother's name.
Birth Date of Baby	YYYY / MM / DD
Tel. Number (where you can be reliably reached)	
Name of Medical Facility	

*Personal information obtained through this application will only be used for the screening and provided as research data as agreed to above. Furthermore, this information will be strictly managed.

<u>Attn. Medical Facility Staff:</u> Please send the Screening Facility Copy of this application together with the blood sample.

英語

Guardian Copy

Expanded Newborn Screening Application & Consent Form (Free)

To: Okayama Expanded Newborn Screening Promotion Association
The Governor of Okayama Prefecture, the Mayor of Okayama City

I have read the "Expanded Newborn Screening Explanation", and having understood the screening (for SMA, SCID, BCD), I would like to apply.

I agree to the use of the blood sample collected for the "Congenital Metabolic Disorder Screening" for these tests.

Additionally, I agree to the provision of data acquired from the screening (for SMA, SCID) to the Children and Families Agency, as well as to the Children and Families Agency Research Group.

Date	YYYY / MM / DD
Applicant's Name (Parent/Guardian)	
Name of Baby's Mother	In case of multiple births, please write the number indicating the baby's order of birth after the mother's name.
Birth Date of Baby	YYYY / MM / DD
Tel. Number (where you can be reliably reached)	
Name of Medical Facility	

*Personal information obtained through this application will only be used for the screening and provided as research data as agreed to above. Furthermore, this information will be strictly managed.