



REQUEST FOR STORAGE OF DRIED BLOOD SPOT

State Form 55651 (R2 / 8-26) / Form S
INDIANA DEPARTMENT OF HEALTH
GENOMICS AND NEWBORN SCREENING PROGRAM

You may request that your child's dried blood spot sample be **stored** for three (3) years after time of collection by completing and sending this form to the Genomics and Newborn Screening (GNBS) Program.

Please review the criteria below to ensure your request is valid:

- If the sample was collected less than six (6) months ago, and you wish to change your consent to reflect your choice to store the sample for three (3) years after time of collection, you may complete and submit this form.
- All samples are kept until the sample has reached six (6) months after time of collection in case additional testing related to newborn screening needs to be performed.
- If you refused the dried blood spot sample storage by checking and signing to decline storage at the time of sample collection, then the sample will be destroyed after six (6) months from collection. All requests submitted for storage of samples older than six (6) months of age will be unable to be fulfilled since the sample has been destroyed.

In order for the Indiana Department of Health GNBS Program to locate your child's dried blood spot sample, certain pieces of information are needed.

Please fill out each of the fields below with the correct information for the child whose dried blood spot sample you are requesting to be **stored**.

First and last name of child at birth	Date of birth of child (<i>month, day, year</i>)
Location of birth (<i>name of the Indiana hospital/midwifery where child was born</i>)	
First and last name of birth mother	Maiden name of birth mother
First and last name of requestor	Requestor's relationship to child
Address of requestor (<i>number and street, city, state, and ZIP code</i>)	
Telephone number of requestor (<i>include area code</i>)	E-mail address of requestor

I hereby request that the dried blood spot sample of the above named child be **stored** and I give permission to the Indiana Department of Health and the state-contracted newborn screening laboratory to complete this request for **storage**.

Signature of requestor	Date of request (<i>month, day, year</i>)
------------------------	---