

Oregon State Public Health Laboratory
7202 NE Evergreen Pkwy. Suite 100
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Phone: 503-693-4100
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Request for Specimen Transfer for CMV Testing at a Reference Laboratory

This form is **2 pages** and is used to request the release of a residual newborn screening bloodspot specimen to a suitable reference laboratory for Cytomegalovirus (CMV) testing by the patient's provider. The requesting provider is responsible for ensuring the informed consent of the patient's parent or legal guardian using this form. Electronic signatures are acceptable.

Please attach a copy of the parent/legal guardian's government issued ID and the complete laboratory test request form for the receiving laboratory.

Patient's Full Name and Date of Birth: _____

Mother's Full Name and Date of Birth: _____

Name of Birthing Hospital, Clinic or Provider: _____

Parent/Legal Guardian's Name (print): _____

Parent/Legal Guardian Address: _____

Parent/Legal Guardian's Phone Number: _____

I, _____ (signature of parent/legal guardian), hereby acknowledge on _____ (date) that I am the parent/legal guardian of the infant patient named above and I request that the Oregon State Public Health Laboratory (OSPHL) transfer my baby's newborn screening bloodspot specimen to _____ Laboratory and I consent to the transfer. I am seeking this transfer for purposes of Cytomegalovirus (CMV) testing. I understand that this request and consent is only for the transfer of the bloodspot residual specimen from the OSPHL to the specified laboratory. I understand this consent does not authorize any specific testing and it is my responsibility to communicate with my baby's health care provider regarding authorization for testing. OSPHL is not legally responsible for the specimen after it is transferred.

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Verification of the identity of Parent/Legal Guardian performed by the Requesting Provider:

Provider's NPI: _____

Provider's Name (print): _____

Provider's Phone Number: _____

Provider's Email Address: _____

_____ (signature) on _____ (date)

(Request for specimen transfer will not occur without this verification.)

OFFICIAL USE ONLY:

OSPHL employee called the phone number of parent/guardian on record with NBS:

_____ (signature) on _____ (date)

Parent/guardian on record with NBS was aware of this request: YES ____ NO ____

Comments: _____

OSPHL employee emailed the Provider to notify of transfer:

_____ (signature) on _____ (date)