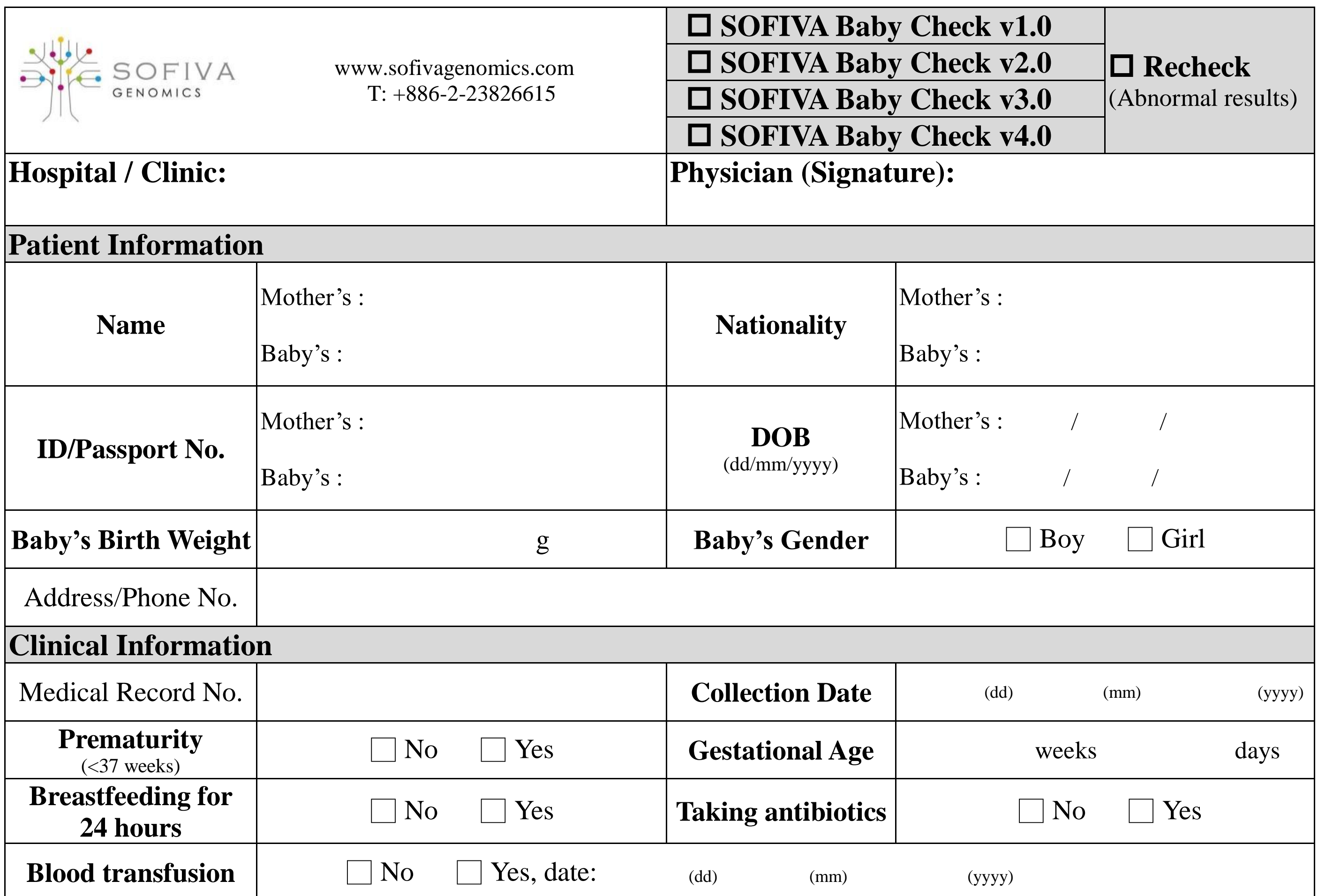
SOFIVA Baby Check

Newborn Metabolic Screening Consent Form



SOFIVA GENOMICS	www.sofivagenomics.com T: +886-2-23826615	☐ SOFIVA Baby Check v1.0 ☐ SOFIVA Baby Check v2.0 ☐ SOFIVA Baby Check v3.0 ☐ SOFIVA Baby Check v4.0	☐ **Recheck** (Abnormal results)
Hospital / Clinic:		**Physician (Signature):**	
Patient Information			
Name	Mother's : Baby's :	**Nationality**	Mother's : Baby's :
ID/Passport No.	Mother's : Baby's :	**DOB** (dd/mm/yyyy)	Mother's : / / Baby's : / /
Baby's Birth Weight	g	**Baby's Gender**	☐ Boy ☐ Girl
Address/Phone No.			
Clinical Information			
Medical Record No.		**Collection Date**	(dd) (mm) (yyyy)
Prematurity (<37 weeks)	☐ No ☐ Yes	**Gestational Age**	weeks days
Breastfeeding for 24 hours	☐ No ☐ Yes	**Taking antibiotics**	☐ No ☐ Yes
Blood transfusion	☐ No ☐ Yes, date: (dd) (mm) (yyyy)		

I, the undersigned, have read the terms and realize the *SOFIVA Baby Check* Newborn Metabolic Screening clearly. I hereby fully understand, agree and undertake the following:

1. This test identifies whether the newborn has any of the listed newborn congenital metabolic disorders at an early phase and provides timely and proper treatment to prevent any physical compromise and/or mental retardation as a result of these disorders.
2. This test helps detect some congenital metabolic disorders without distinct symptoms at an early phase, provide proper diagnosis and treatment during the golden treatment period, and minimize the disease's damage on the body and/or mind.
3. In the event that a result indicates abnormality, the patient is strongly advised to consult with your pediatrician in order to obtain a complete understanding of the contents and implications of the report.
4. Due to the considerable variety of diseases as well as the inherent limitations of any test, this test cannot identify all possible conditions. Therefore, a negative result does not guarantee that the newborn is normal.
5. This test involves collecting an adequate amount of blood to be mounted on a blood card. However, there is an extremely small chance that the blood spot will not be sufficient to perform the test. In these cases, a repeat sample will be required.
6. I hereby agree that the hospital/clinic and Sofiva Genomics may collect, process or use my personal information such as medical records, medical treatment, genetic information and health examination records under the specific purpose of medical care, health treatment, etc.
7. I ☐agree / ☐do not agree to allow the remainder of my sample to be used for research purposes. (Lack of response indicates consent.)
8. According to my situation, the physician has answered all my questions and adequately explained to me (included but not restricted to the information about the necessary, process, potential risk and successful rate of this test as well as the risk of other screening tests).
9. I fully understand the above terms, statements, and declarations, and I agree to have this test performed at my own expense. I understand and accept that this test may be the most appropriate choice at this time, but it cannot guarantee the prevention of the tested disorders.

Signature, Date (dd/mm/yyyy)

Copy 1: Laboratory Retain (White) Copy 2: Hospital/Clinic Retain (Blue) Copy 3: Patient Retain (Red)