Task Force on Inborn Metabolic Disorders

CONSENT FORM

Mrs. ______________________ W/o ____________________. I hereby give my consent to give my babies blood for newborn screening. I have been explained about the procedure and likely benefits of screening. I also understand that I may need to visit my doctor again and retesting of the baby may be required. I have also been explained that I can withdraw from the study at any time without compromising the care of my child. My participation in the study is totally voluntary.

Yes /No — I agree to have the remaining blood spots be stored and used for research purposes and the confidentiality will be maintained.

Mother's signature / Thumb impression

Name ____

W/O ____

Address ____

(Present & Permanent)

____

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Phone # ____

Email ____

Fax # ____

Father'/Mother's signature/Thumb impression :

Signature of the study Doctor/Study staff ______________________________
Name in block letters

Date ______________________