Public Health Division

Oregon State Public Health Laboratory

OREGON HEALTH AUTHORITY

Tina Kotek, Governor

Request for Specimen Transfer for CMV Testing

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. The provider is also responsible for arranging CMV testing with a suitable reference laboratory.

Please complete all fields below and confirm the performance of identity verification on page 2, then **attach the following *three* required documents in a single, secured email** to the Oregon State Public Health Laboratory (OSPHL) at osphl.recordsrequest@oha.oregon.gov.

1) This completed *Request for Specimen Transfer for CMV Testing* form (page 1 & page 2).
2) A copy of the government issued photo ID (front & back) of the parent/legal guardian below.
3) A copy of the completed, official laboratory test requisition form from the reference laboratory, which must include the patient's first and last name, date of birth, and date of specimen collection.

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 _____ (name of reference 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.

7202 NE Evergreen Pkwy, Suite 100, Hillsboro, OR 97124

Voice: 503-693-4100 | Fax: 503-693-5602 | All relay calls accepted | www.healthoregon.org/phl

Public Health Division

Oregon State Public Health Laboratory

Tina Kotek, Governor

Request for Specimen Transfer for CMV Testing

Verification of the identity of the Parent/Legal Guardian listed on page 1 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:

a) OSPHL employee called the phone number of the parent/legal guardian on record with NBS, and the parent/legal guardian was aware of this request: YES __ NO __

_____ (signature) on _____ (date)

Comments: _____

b) OSPHL employee emailed either a specimen transfer denial letter or transfer confirmation with shipping/tracking ID to the provider listed above. (circle one)

_____ (signature) on _____ (date)

Comments: _____

_____

7202 NE Evergreen Pkwy, Suite 100, Hillsboro, OR 97124

Voice: 503-693-4100 | Fax: 503-693-5602 | All relay calls accepted | www.healthoregon.org/phl