TEXAS DEPARTMENT OF LICENSING & REGULATION

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www.tdlr.texas.gov

NEWBORN SCREENING AGREEMENT FOR NEWBORN BABIES OF MIDWIFE CLIENTS

DOCUMENTS SUBMITTED WILL NOT BE RETURNED. KEEP A COPY OF YOUR COMPLETED FORM.

MIDWIFE'S INFORMATION

Name: _____ (Last) _____ (First) _____ (Middle)

Phone Number: _____ (Area Code) Phone Number

Mailing Address: _____ (Address, City, State, Zip Code)

I acknowledge and attest to my responsibility for ensuring that each child whose birth i attend is subjected to newborn screening tests in accordance with the requirements of the Newborn Screening Program at the Texas Department of State Health Services (DSHS). I will refer my clients to the physician or health care facility designated below for the collection of blood specimens and submission of the specimens to DSHS for the performance of the newborn screening tests.

_____ Signature of Midwife

_____ Date

PHYSICIAN OR HEALTH CARE FACILITY INFORMATION

Name: _____ (Last, First, Middle Name, Suffix (Jr., Sr., III))

Phone Number: _____ (Area Code) Phone Number

Name of Office: _____

Mailing Address: _____ (Address, City, State, Zip Code)

Please check one of the following options before signing below:

☐ I am a physician, and i agree to collect blood specimens for the clients of the midwife identified above and to submit the specimens to DSHS for the performance of the required newborn screening tests.

☐ I am an authorized representative of the health care facility identified above, and the facility agrees to collect blood specimens for the clients of the midwife identified above and to submit the specimens to DSHS for the performance of the required newborn screening tests.

Signature:

_____ Signature of Physician or Authorized Representative of Health Care Facility

_____ Date