Appendix L

California Department of PublicHealth

Consent & MSAFP Order Confirmation

California Prenatal Screening Program

Attach Accession Label
For state lab use only
Do not cover

Patient

Last Name:	Smith
First Name:	Stacy
Medical Record #:	
Date of Birth:	06/01/1991
Patient Phone #:	(408) 000-0000

Order

PNS Form #:	S 22 04633 53
Clinician Last:	Green
Clinician First:	Jon
Clinician Phone #:	(408) 000-0000

Patient Consent

If you give consent to prenatal screening by signing below, your blood will be collected and sent to a state-contracted laboratory for prenatal screening.

- *I consent to participate in the California Prenatal Screening Program.*
- *I authorize the release of medical and any other information about myself that is needed for my health insurance claim.*
- *I authorize payment of medical benefits to the Genetic Disease Screening Program (GDSP) for the services provided to me.*
- *I consent to be billed directly for services provided to me if I do not have health insurance coverage or Medi-Cal.*
- *I agree my blood sample may be used for research by GDSP or GDSP-approved researchers, unless the box below is marked.*

☐ *I decline the use of my specimen for research.*

Patient/Authorized Person Signature: _____ **Date:** M M / D D / Y Y Y Y

☐ Attestation that verbal consent from patient was obtained:

Provider/Representative Name **Relationship to Patient**

Based on Gestational Age, the recommended patient blood draw date range: 10/17/2022 – 11/28/2022

Blood Sample

Blood Draw Facility Name

Blood Draw Date M M / D D / Y Y Y Y

Collector's Initials

Blood Draw Facility Phone # - -

NAPS Lab Notes

Copy of insurance card ↓	Blood draw tube ↓	Extra label ✓	Do not remove ✕
Smith, S	Smith, S	Smith, S	Smith, S
S 22 04633 53	S 22 04633 53	S 22 04633 53	S 22 04633 53
Collected on: __/__/_____	Collected on: __/__/_____	Collected on: __/__/_____	Collected on: __/__/_____