State of New Jersey
Department of Health

NOTICE OF AVAILABILITY OF SUPPLEMENTAL NEWBORN SCREENING

Mandated Newborn Screening
New Jersey law mandates that every baby born in New Jersey receive:
- Newborn Biochemical (Bloodspot) screening
- Hearing screening
- Critical Congenital Heart Defect (pulse oximetry) screening

For more information about the NJ Newborn Screening Program see https://www.nj.gov/health/fhs/nbs/

Supplemental (additional, optional) screening
The purpose of this notice is to inform expectant parents that New Jersey does not test for every possible birth defect and that additional, supplemental, testing is available for defects for which the State does not screen, should you choose to pursue further screening.
- **Supplemental** screening is performed by private laboratories and may not be covered by your insurance plan.

The results of any supplemental screening tests are sent to the ordering health professional and NOT to the NJ Newborn Screening Program.

For more information about supplemental testing, visit:
https://www.babysfirsttest.org
https://babyfoodsteps.wordpress.com/babynewborn-screeningsteps/supplemental-newborn-screening/ *

For general information about Newborn Screening see
https://www.babysfirsttest.org/newborn-screening/screening-101 *
*The NJ Department of Health is not responsible for the content of these web pages.

If you have any questions, please contact your healthcare provider.

Acknowledgement of Receipt of Notice of Availability of Supplemental Newborn Screening

By signing this form, I confirm that:
- My health care provider gave me the notice titled "Notice of Availability of Supplemental Newborn Screening" and I kept a copy of the notice; and
- My health care provider gave me a reasonable opportunity to read the notice and ask questions; and
- I understand that mandated newborn screening performed by the New Jersey newborn screening laboratory will not detect all birth defects in infants for which tests are available; and
- I understand that I am personally responsible for the cost of additional, supplemental, newborn screening laboratory services that I choose to pursue.

Relationship to Newborn (check one): Parent Guardian Date: ______________________

Print Name: ______________________ Signature: ______________________

Print Name of Witness: ______________________ Signature: ______________________

The health care provider shall maintain the signed original of this acknowledgement.
The health care provider shall give the signer a copy of this notice titled, "Notice of Availability of Supplemental Newborn Screening."