Request for Information - Antenatal and Newborn Screening Programmes

Application date: _____

This form must be completed by the person (applicant) requesting information from the Antenatal and Newborn Screening Programmes, including use of residual blood spot samples for research and evaluation purposes.

If the request is for research, Ethics Committee application and approval must accompany this form.

Contact details for sending this form

It is preferred that you email your request to: Samuel.Cussen@health.govt.nz

Alternatively you can send to:

Samuel Cussen
Team Administrator
Antenatal & Newborn Screening
National Screening Unit
Ministry of Health
Private Bag 92522
AUCKLAND 1141

For enquiries regarding applications please contact Moira McLeod, Team Leader, Antenatal & Newborn Screening on (09) 580 9086 or email: Moira.McLeod@health.govt.nz

1. Screening programmes / quality improvement initiatives *(Please tick)*

☐ Quality improvements for antenatal screening for Down syndrome and other conditions

☐ Universal Newborn Hearing Screening and Early Intervention Programme

☐ Newborn Metabolic Screening Programme

2. Applicant contact details

Name:

Organisation:

Department/Section:

Physical Address:

Telephone, mobile phone:

Email:

Date request submitted:

3. Request Summary

Please provide a detailed description of the request. Use separate pages as required.

4. Purpose (reason for requesting data / residual blood spot samples)

Full description of what the data / residual blood spot samples will be used for. Use separate pages as required.

5. Timeframes

When are the data / residual blood spot samples required by – give reasons, include project start and end dates.

6. Format in which data is required

For example, Excel spreadsheet.

7. Data elements

Description of the data elements to be extracted, including whether aggregate or unit record is required, list of particular fields that are required. To avoid delays it may be useful to phone to discuss and clarify requirements and check availability of data.

8. Ethics committee approval

Please provide ethics committee application if this data / residual blood spot sample request is part of research work, and responses received from the ethics committee. If ethics committee approval has not been obtained, please provide reasons.

9. Security of data / residual blood spot samples

Provide detail of how data / residual blood spot samples will be stored and secured.

10. Provide detail of who will have access to data / residual blood spot samples

11. Provide detail of confirmation that data / residual blood spot samples will be destroyed after use

12. Confirm that data / residual blood spot samples will not be shared with anyone other than those named above *(ie: the applicant plus other named individuals)*

13. Confirm that data / residual blood spot samples will only be used for the purpose specified above

14. Confirm that the applicant has the necessary skills / access to skills to undertake analysis for the specified purpose

15. Confirm that a copy of any report prepared using this data / results of residual blood spot sample testing will be provided in confidence to the National Screening Unit (pre-publication)

16. Confirmation that any report prepared using this data / results of residual blood spot sample testing in whole or in part will acknowledge the National Screening Unit as the source of the data

Declaration

We the undersigned confirm that the information provided in this form is accurate to the best of our knowledge.

Name of Applicant: _____

Signed: _____ Date: _____

Manager / Director: _____

Signed: _____ Date: _____