Refusal of Consent for Sweat Test

I, the parent/ legal guardian of _____, born on _____
Full name of infant Date of birth

refuse to have my child receive a sweat test.

I understand that the newborn screening results show that my child is at risk for a serious medical condition called Cystic Fibrosis.

I understand that a sweat test is needed to know whether my child has Cystic Fibrosis.

I understand that the benefit of doing a sweat test is so that babies who do have Cystic Fibrosis can be treated as early as possible. My decision to refuse the testing was made freely and without force or encouragement by my doctor, my baby's doctor, the hospital staff, or state officials.

I accept all responsibility, legal and otherwise, for this decision.

_____ _____ _____
Full printed name of mother Signature Date

_____ _____ _____
Full printed name of father Signature Date

_____ _____ _____
Full printed name of licensed healthcare provider* Signature Date

* Licensed healthcare providers include physicians, nurses, and midwives.

Print name of hospital: _____

Instructions:

1. Complete this form for each infant when at least one parent refuses the sweat test. The signature of the infant's other parent is not required (but is requested) if that parent also refuses.
2. Provide a copy of the form to the parents and send a copy to the baby's primary care provider.
3. Keep the original for your records.
4. Fax a copy of this form to 401-222-5688 to the attention of the Newborn Screening Program.
5. For additional forms, please print from the Rhode Island Department of Health website at https://health.ri.gov/publications/bytopic.php?parm=Newborn%20Screening#Parents. Refusal forms are located in the "Publications for Parents" section on the right side of the screen.