Refusal of Consent for Newborn Blood Screening

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

refuse to have blood taken from my child to determine if he or she might have a metabolic, endocrine, hemoglobin, or other disorder that can be detected through newborn screening. Metabolic refers to how the body digests food. Endocrine refers to how the body controls many functions. Hemoglobin refers to blood.

I have been informed that newborn screening is mandated for all babies born in Rhode Island unless the screening conflicts with the religious tenets and practices of the parent(s).

I have read the Newborn Screening and Services Brochure and discussed newborn screening with my baby's doctor, midwife, a member of the hospital nursing staff, or other healthcare provider.

I understand that the screening is done for the early detection of treatable disorders. I understand that symptoms sometimes do not appear for several weeks or months.

I understand that when newborn screening conditions are not detected and treated in the newborn period, there can be permanent damage such as mental retardation, developmental delays, growth failure, and even death.

I understand the benefits of newborn screening. The potential dangers of not being screened have been explained to me. My decision to refuse the testing was made freely and without force or encouragement by my doctor or midwife, my baby's doctor, the hospital staff, or state officials.

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

_____

Full name of mother Signature Date

_____

Full name of father Signature Date

_____

Full name of licensed healthcare provider* Signature Date

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

Check one: ☐ Hospital birth ☐ Home birth

Healthcare provider instructions:

1. Have the parent(s) read the Newborn Screening and Services Brochure.
2. Complete this form for each infant when the parent(s) refuse(s) newborn screening.
3. Provide a copy of the form to the parents and send a copy to the baby's primary care provider.
4. Keep the originals for your records.
5. Fax a copy of this form to 401-222-5688 to the attention of the Newborn Screening Program.
6. 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. Forms are found under the "Parents" section on the right side of the screen.