



Refusal of Consent for Critical Congenital Heart Disease Screening

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

refuse to have my child (check all that apply):

- Receive Pulse Oximetry screening
- Receive Echocardiogram evaluation (ECHO), if needed
- Transported to another facility, if needed

I understand that Pulse Oximetry screening is done for the early detection of Critical Congenital Heart Disease. This dangerous heart condition can cause death or permanent disability if it is not detected early.

I have read the Newborn Screening Pulse Oximetry brochure insert and discussed Pulse Oximetry Screening with my baby’s doctor, midwife, a member of the hospital nursing staff, or other healthcare provider.

I understand the benefits of screening, evaluation, and transport. The potential dangers of not receiving these services have been explained to me. My decision to refuse screening, evaluation, and/or transport 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 printed name of mother Signature Date

Full printed name of father Signature Date

Full printed name of healthcare provider* Signature Date

* Healthcare providers include physicians, nurses, and midwives.

Healthcare provider instructions:

1. Have the parent(s) read the Critical Congenital Heart Disease insert in the Newborn Screening and Services brochure. Discuss Pulse Oximetry screening and potential follow up services (echocardiogram evaluation, transport to another facility) with the parent(s). Review the benefits of these services and the potential dangers of not receiving them.
2. Complete this form for each infant when the parent(s) refuse(s) Pulse Oximetry screening, echocardiogram evaluation, and/or transport to another facility.
3. Provide a copy of the form to the parents and send a copy to the baby’s primary care provider.
4. Keep the original for your records
5. fax a copy of this form to (401)-222-1088 attn Newborn Screening
6. For additional forms, please print from the Rhode Island Department of Health website at <http://www.health.ri.gov/forms/refusalofconsent/PulseOximetry.pdf>