Refusal of Consent for Newborn Blood Screening

I/We, the parent(s) of ______________________________________, born on ______________________,
Full name of infant — Date of birth

refuse to have blood taken from my/our child for the purpose of determining if he or she might have a metabolic, endocrine, hemoglobin, or other disorder that can be detected through newborn screening.

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

I/We have read the Newborn Screening and Services Brochure and discussed newborn screening with my/our baby's doctor, midwife, a member of the hospital nursing staff, or other healthcare provider. I/We feel that all of my/our questions have been answered to my/our satisfaction.

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

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

I/We accept all responsibility, legal and otherwise, for the consequences of this decision.

Required:	Full name of mother	Signature	Date
Encouraged:	Full name of father	Signature	Date
Required:	Full name of licensed healthcare provider	Signature	Date

Check one: ☐ Hospital birth ☐ Home birth

Healthcare provider instructions:

1. Have the parent(s) read the Newborn Screening and Services Brochure insert listing and describing the disorders included in newborn screening.
2. Complete this form for each infant when the parent(s) refuse(s) newborn screening.
3. Send the original form to the Rhode Island Newborn Screening Program at the Rhode Island Department of Health, Three Capitol Hill, Room 302, Providence, RI 02908.
4. Provide a copy of the form to the parents and send a copy to the baby's primary care provider.
5. Keep a copy for your records.
6. For additional forms, please print from Rhode Island Department of Health website at www.health.ri.gov/newbornscreening/for/providers. Refusal forms are located in the "Forms" box on the right side of the page.

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