Newborn Metabolic Screening Test Refusal Form

Name of Newborn	Birth Date
Hospital/Place of Birth	Mother's Resident Address
Medical Record Number	City/State/Zip

I have received the parent informational brochure entitled, "**Newborn Screening Could Save Your Baby's Life,"** concerning the newborn metabolic screening tests for phenylketonuria (PKU), congenital hypothroidism, congenital adrenal hyperplasia (CAH), cystic fibrosis (CF), maple syrup urine disease (MSUD), galactosemia, biotinidase deficiency, hemoglobin disorders, other amino acid disorders, urea cycle disorders, organic acid disorders, and fatty acid oxidation disorders.

I have been informed and I understand that these tests are required by State law for all infants born in Hawaii.

I have been informed and I understand that these tests are given to detect these disorders as symptoms may not appear for several weeks or months.

I have been informed and I understand that, if untreated, these conditions may cause permanent damage to my child, including serious intellectual disabilities, growth failure, and even death.

I have been informed and I understand the nature of these tests and how these tests are given.

I have discussed this test with _____ and I understand the risks involved if these tests are not given to my child.

I object to these tests and refuse to have my newborn child tested on the grounds that these tests conflict with my religious tenets and beliefs.

My decision was made freely without force or encouragement by my doctor, hospital personnel, or any State official.

Parent's or Legal Guardian's Name (Print)	Parent's or Guardian's Signature
Witness's Signature	Date

Hawaii State Department of Health
Newborn Metabolic Screening Program
741 Sunset Avenue, Honolulu, HI 96816
Phone: (808) 733-9069 Fax: (808) 733-9071

COPIES TO:
1) Infants' Medical Record
2) Department of Health/Newborn Metabolic Screening Program
3) Parents

Updated 08/20