STATE OF HAWAIʻI
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
CHILDREN WITH SPECIAL HEALTH NEEDS BRANCH
741 SUNSET AVENUE
HONOLULU, HI 96816
Newborn Metabolic Screening Program
Phone (808)733-9069 | Fax (808)733-9071 | eFax (808)207-0067

Test Refusal Form

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

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 hypothyroidism, 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, fatty acid oxidation disorders, Pompe disorder, and mucopolysaccharidosis Type-I (MPS-I) .

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

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.
Provider

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 Legal Guardian's Name (SIGNATURE)**	**Date**
Medical Professional Witness' Name (PRINT)	**Medical Professional Witness' Name (SIGNATURE)**	**Date**

COPIES TO:
1) Hospital's Medical Records Department
2) State of Hawaiʻi Newborn Metabolic Screening Program
3) Parent or Legal Guardian of Newborn