



**STATE OF HAWAII**  
 DEPARTMENT OF HEALTH  
 KA 'OIHANA 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 – Initial

Submit within 48 hours of birth and/or no later than 30 days of signature

<b>Name of Newborn (LAST, FIRST)</b>	Date of Birth
<b>Hospital / Place of Birth</b>	Medical Record Number
<b>Address of Mother</b>	City / State / Zip Code

<b>Acknowledgement</b>	<b>Initials</b>
I have received the parent informational brochure entitled, “ <b>Newborn Screening Could Save Your Baby’s Life,</b> ” concerning the newborn metabolic screening tests for amino acid disorders, biotinidase deficiency, congenital adrenal hyperplasia (CAH), congenital hypothyroidism (CH), cystic fibrosis (CF), fatty acid oxidation disorders, galactosemia, hemoglobin disorders, maple syrup urine disease (MSUD), mucopolysaccharidosis Type-I (MPS-I), organic acid disorders, phenylketonuria (PKU), Pompe disorder, spinal muscular atrophy (SMA), urea cycle disorders, and x-linked adrenoleukodystrophy (X-ALD).	
I have been informed and I understand that these tests are required by state law for all infants born in Hawai‘i.	
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.	

<b>Acknowledgement</b>	<b>Initials</b>
I have been informed and I understand the nature of these tests and how these tests are given.	
I have discussed this test with _____ (provider name) and I understand the risks involved if these tests are not given to my child.	
<b>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.</b>	
My decision was made freely without force or encouragement by my doctor, hospital personnel, or any State official.	

<b>Parent's or Legal Guardian's Name (PRINT)</b>	Parent's or Legal Guardian's Name (SIGNATURE)	Date
<b>Medical Professional Witness' Name (PRINT)</b>	Medical Professional Witness' Name (SIGNATURE)	Date

**COPIES TO:**

- 1) Hospital's Medical Records Department
- 2) State of Hawai'i Newborn Metabolic Screening Program
- 3) Parent or Legal Guardian of Newborn