



STATE OF HAWAI'I
 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 – Repeat
 Submit no later than 30 days of signature

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

Acknowledgement	Initials
I have received the parent informational brochure entitled, “ Newborn Screening Could Save Your Baby’s Life, ” 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.	
I have been informed and I understand the nature of these tests and how these tests are given.	

Acknowledgement	Initials
I have discussed this test with _____ (provider name) and I understand the risks involved if these tests are not given to my child.	
I object to having a repeat newborn metabolic screening collected.	
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 Hawai'i Newborn Metabolic Screening Program
- 3) Parent or Legal Guardian of Newborn