New England Newborn Screening Program
University of Massachusetts Medical School

Commonwealth of Massachusetts
Department of Public Health

Form to Document Parent/Guardian Refusal of Mandated Newborn Screening

Fax to New England Newborn Screening Program 617-522-2846 [phone 617-983-6300]

Infant Identifiers

Birth certificate ID (if available)_____

Infant's surname_____ Infant's given name_____

Gender_____ Infant's Date of birth_____

Infant's Hospital of birth_____ (mm/dd/yyyy)

Maternal surname _____Maternal given name_____

Maternal address_____

PARENT(S)/GUARDIAN(S):

I/We understand that Massachusetts law and regulations [105 CMR 270.000] require all newborns in Massachusetts to be tested (unless parents or guardians object on the basis of religious tenets or practices) for certain conditions that, if untreated, can cause mental retardation and other serious health problems.

I/We understand that the purpose of Mandated Newborn Screening is to test all newborns in Massachusetts for early signs of a number of treatable conditions and that symptoms sometimes do not appear for several weeks or months after birth.

I/We understand that if my baby has a condition included in Massachusetts Mandated Newborn Screening and I/we object to Mandated Newborn Screening, I/we risk that my/our baby's condition may not be diagnosed until it is too late, causing permanent damage to my/our child, including serious mental disability, growth failure, coma, or, in some cases, death.

The benefits of newborn screening and the potential danger of not being screened have been explained to me/us. I/We have had the opportunity to discuss newborn screening with our baby's doctor, the hospital nursing staff, or other care provider, and all of our questions have been answered. My/Our decision to refuse newborn screening testing was made freely without force or encouragement by my doctor, my baby's doctor, hospital personnel, or State officials.

I/We acknowledge that this form will be filed in our baby's medical record, and copies will be sent to our baby's care provider and the New England Newborn Screening Program.

I/we refuse Mandated Newborn Screening **for my/our baby named above** for religious reasons.

PRINTED NAME OF FIRST PARENT OR GUARDIAN_____ RELATIONSHIP: _____

SIGNATURE OF FIRST PARENT OR GUARDIAN_____DATE:_____

PRINTED NAME OF SECOND PARENT OR GUARDIAN _____ RELATIONSHIP: _____

SIGNATURE OF SECOND PARENT OR GUARDIAN_____DATE:_____

(required if second parent or guardian also has legal custody)

WITNESS /Attending Physician_____DATE: _____

Printed name and signature

MEDICAL PERSONNEL:

I have explained the Massachusetts requirements for newborn screening, the purpose and method of newborn screening, and the possible consequences **to the infant named above** if newborn screening is not allowed by the infant's parent(s) or guardian(s). I have answered any questions the parent(s) or guardian(s) named above had about newborn screening.

Attending Physician _____

(printed name and title) (signature and date)

Hospital or Practice_____

(name) (address) (phone/email)

If parents refuse screening AND refuse to sign, please document refusal with another witness

_____

Printed Name of Witness who is not Attending physician Signature of Witness Date

Form available for distribution July 2014