DEPARTMENT OF HEALTH

REV 01/2023

PLACE PATIENT LABEL TO COVER OR COMPLETE BELOW

Baby's Name (LAST, FIRST) _____

Date of Birth _____

Mother's Name (LAST, FIRST) _____

Hospital / Midwife _____

Parental Refusal or Delay of Newborn Screening

You have the right to refuse or delay having your baby screened. Select and initial below which part(s) of newborn screening you wish to refuse or delay.

You have been informed of the risks of delaying and/or not screening your baby. Signing this form means you are refusing screening ***at this time***. You can choose to have your baby screened at a later time. If you choose to have newborn screening done later, MDH strongly encourages completing screening within one week of age when screening is most accurate.

Should you choose to have your baby screened and do not want MDH to keep your baby's test results and blood spots, there is the option to have them destroyed at any time. Please see the MDH Newborn Screening Program website for the required form www.health.state.mn.us/people/newbornscreening

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BLOOD SPOT

I understand signs and symptoms of disease can occur within the first few days of life. Some signs and symptoms may not show for several weeks or months. Permanent health problems or death can occur if these diseases are not identified and treated early.

☐ **REFUSE** _____ Parent/Guardian Initials

☐ **DELAY** _____ Witness Initials

HEARING

I understand that hearing loss may not be noticeable at birth without screening. Any amount of hearing loss may delay speech, language, emotional and social development.

☐ **REFUSE** _____ Parent/Guardian Initials

☐ **DELAY** _____ Witness Initials

PULSE OXIMETRY

I understand that the signs and symptoms of heart defects sometimes do not appear for several weeks or months. Permanent damage or death can occur if not identified and treated early.

☐ **REFUSE** _____ Parent/Guardian Initials

☐ **DELAY** _____ Witness Initials

For any **DELAYED** screenings, please provide the name of who will complete your baby's screening:

Clinic/provider/midwife name: _____

Parent or Guardian Printed Name: _____

Parent or Guardian Signature: _____ Date: _____

Relationship to Newborn: _____ Phone Number: _____

TO BE COMPLETED BY HOSPITAL / MIDWIFE ONLY

Witness Printed Name: _____

Witness Signature: _____ Witness Title / Role: _____

Second Witness Printed Name (optional): _____

Second Witness Signature (optional): _____

☐ The parent(s) / guardian(s) have refused or delayed some or all parts of the newborn screen **and** have elected not to sign.

Parental Refusal or Delay of Newborn Screening

Hospital/Midwife Instructions for Completing this Form

Page 1 of the *Parental Refusal or Delay of Newborn Screening* form must be completed. The signed form must be made part of the infant's medical record and a copy shall be provided to the Department of Health (MN Statute 144.125).

To streamline the process and avoid multiple contacts from newborn screening staff, please fax or mail the form to MDH within seven days of birth.

Call **651-201-5466** with any questions.

Original form to:
Newborn's Medical Record

Copy to:
Minnesota Department of Health
Newborn Screening
P.O. Box 64899
St. Paul, MN 55164-0899

Fax: (651) 215-6285
Email: health.newbornscreening@state.mn.us

Copy to:
Parent / Legal Guardian

Copy to:
Primary Care Provider / Clinic