



Parental Refusal or Delay of Newborn Screening

တၢ်ဟ့ၣ်စိဟ့ၣ်ကမၤ လၢ ကထုးထီၣ်ရၤလီၤ တၢ်အိၣ်ဆူၣ်အိၣ်ချ့ တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢတၢ်ဒိသဒါအီၤ ဆူ ပှၤတဲကျိးထံ

Place patient label to cover or complete below

Baby's Name (LAST, FIRST)

Date of Birth

Mother's Name (LAST,FIRST)

Hospital/Midwife

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

health.state.mn.us/people/newbornscreening

ပုဂ္ဂိုလ်
Refuse

မိဘ/ပုဂ္ဂိုလ်ထွဲတော် ဆဲးလီမံ
Parent/Guardian Initials

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.

Delay

ပုၤအိုၣ်သး ဆဲးလီၤမံၤ
Witness Initials

ယန္တိပင်္ဂါလ၊ တိန်ဟူ လီၤမၢ်ကွံာ်န့ၣ် တၢ်တသုၣ်ညါ ဟံသ့ၣ်ဟံသးအီၤ ဖဲတၢ် အိၣ်ဖျၢၣ်ထီၣ် လၢတအိၣ်ဒီး တၢ်သမသမိးဘၣ်န့ၣ်လီၤ. တိန်ဟူလီၤမၢ်ကွံာ် အိၣ် ထံလဲၣ်န့ၣ် ကမၤစၢ်ခံ တၢ်ကတိၤ, ကျိၣ်, သးအတၢ်တူၢ်ဘၣ် ဒီး ပုၤတၢ်တၢ်ရဲလိာ်မၢ်လိာ် တၢ်ဒိၣ်ထီၣ် န့ၣ်လီၤ.

ပုဂ္ဂိုလ်
Refuse

မိဘ/ပုဂ္ဂိုလ်ထွဲတော် ဆဲးလီမံ
Parent/Guardian Initials

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.

Delay

ပုၤအုၣ်သး ဆဲးလီၤမံၤ
Witness Initials

သွန်စဉ်	ယန့်ပာ်လၢ သးဖျၢၣ် တဘၣ်လိာ်ဘၣ်စး တၢ်ပနီၣ် ဒီး တၢ်ဆါပနီၣ်တဖၣ်န့ၣ် တဘျီတခီၣ် တဖျါထီၣ်လၢ တဘျးန့ၣ် မ့တမ့ၢ် တဘျးလၢ အတီၢ်ပူၤဘၣ်န့ၣ် လီၤ. တၢ်ဟးဂီၤတစါသး မ့တမ့ၢ် တၢ်သံတၢ်ပုၤ အိၣ်ထီၣ်သ့ ဖဲ တၢ်မ့ၢ်တသ့ၣ် ညါဒီးကူစါဆိ အီၤဘၣ်န့ၣ်လီၤ.	ဂုၤလိာ် Refuse	မိၢ်ပာ်/ပုၤကွၢ်ထွဲတၢ် ဆဲးလီၤမံၤ Parent/Guardian 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.	စဲၤခံ Delay	ပုၤအုၣ်သး ဆဲးလီၤမံၤ Witness Initials

လၢ တၢ်သမံသမိး **တၢ်စဲၤခံကွၢ်** တမံၤလၢလိာ်အဂီၢ်, ဝံသးစူၤ ဟ့ၣ်လီၤ ပုၤလၢအကမၤပဲၤ နဖီ အတၢ်သမံသမိးအမံၤ-

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

တၢ်ဆါတံၣ်/ ပုၤကွၢ်ပုၤဟး
Clinic/provider/midwife name:

မိၢ်ပာ် မ့တမ့ၢ် ပုၤကွၢ်ထွဲတၢ် ကွဲးလီၤမံၤ-
Parent or Guardian Printed Name:

မိၢ်ပာ် မ့တမ့ၢ် ပုၤကွၢ်ထွဲတၢ် ဆဲးလီၤမံၤ-
Parent or Guardian Signature:

တၢ်ဘၣ်ထွဲဒီး ဖိသၣ်အိၣ်ဖျၢၣ်သီ-
Relationship to Newborn:

မုၢ်နီၤ-
Date:

လီၤတဲစိနီၣ်ဂီၢ်-
Phone Number:

တၢ်ဆါတံၣ်/ပုၤကွၢ် ပုၤဟး တၢ်န့ၣ်ကျဲတဖၣ် လၢ တၢ်မၤပဲၤ လံာ်ကွၢ်ဒိအံၤ အဂီၢ်
Hospital/Midwife Instructions for Completing this Form

ပုၤအုၣ်သး ကွဲးလီၤ မံၤ-
Witness Printed Name:

ပုၤအုၣ်သး ဆဲးလီၤမံၤ-
Witness Signature:

ပုၤအုၣ်သးခံၤတဂၤ ကွဲးလီၤမံၤ (မၤပဲၤသ့ တမၤပဲၤသ့)-
Second Witness Printed Name (optional):

ပုၤအုၣ်သးခံၤတဂၤ ဆဲးလီၤမံၤ (မၤပဲၤသ့ တမၤပဲၤသ့)-
Second Witness Signature (optional):

မိၢ်ပာ်(တဖၣ်)/ပုၤကွၢ်ထွဲတၢ်(တဖၣ်) ဂုၤလိာ် မ့တမ့ၢ် သးယံၤထီၣ်ဝဲ ဖိသၣ်အိၣ်ဖျၢၣ်သီ တၢ်သမံသမိး အဆၢကတီၢ် **ဒီး** ဃုထၢလၢ တဆဲးလီၤမံၤဘၣ်န့ၣ်လီၤ.
The parent(s) / guardian(s) have refused or delayed some or all parts of the newborn screen **and** have elected not to sign.

မိဘ/ပုဂ္ဂိုလ် မှတ်တမ်း သမာ ဖိသိပ်အိပ်ယူသည့် တာသမံသမိး

လာ တာဆိဟံ/ပုဂ္ဂိုလ် ပုဂ္ဂိုလ် ကမာပဲအင်္ဂါ

To be completed by hospital/midwife only

တာကဘဉ်မာပဲ၊ မိဘ/ပုဂ္ဂိုလ် (Parental Refusal) မှတ်တမ်း တာစဲအံ
လာ ဖိသိပ်အိပ်ယူသည့် တာသမံသမိး (Delay of Newborn Screening)
လာ်ကွီဒ် အကျဲးပာ 1 နှာ်လီ။ တာကဘဉ်မာ လာ်ကွီဒ် လာအိပ်ဒီး
တာဆဲးလီမံ၊ လာ ဖိသိပ်ဆဲးဖိ အကသိပ်ကသီ တာမာနီာ်မာယါ အ
ကွာ်အင်္ဂါ ဒီး တာကဘဉ်ဟံလီ၊ အကွဲးဒီး ဆူ တာအိပ်ဆူာ်အိပ်ဆူာ်
ကျဲ (Department of Health) (MN သဲးတာသိပ်တာသိ အကွာ်
144.125) နှာ်လီ။

လာကသုာ်ညါ တာမာအကျဲအကျဲ ဒီးဟးဆဲး တာဆဲးကျဲ၊ တာဘျဲးမံ၊
လာ ဖိသိပ်အိပ်ယူသည့် တာသမံသမိး အပုဂ္ဂိုလ်တာဖိ အင်္ဂါ၊ ဝံသးစူ၊ ဆူာ်
လာ်ကွီဒ် ဒီးဖိ ဖဲး(စ) မှတ်တမ်း လာ်ပရ၊ တား ဆူ MDH ဖဲးအိပ်ယူသိ နှံ
သီအတာ်ပူ၊ နှာ်တကွာ်။

ကိး 651-201-5466 ဖဲးအိပ်ဒီး တာသံကွာ်တမံလံလံ နှာ်တကွာ်။

လာ်ကွီဒ် နီကီ ဆူ-

Newborn's Medical Record

အကွဲးဒီး ဆူ-

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

အကွဲးဒီး ဆူ-

မိဘ/ ပုဂ္ဂိုလ်ထွဲတာ လာအဖိးသဲး

အကွဲးဒီး ဆူ-

ပုဂ္ဂိုလ်ဂံခိာ်ထံး တာကွာ်ထွဲ တာမာစာ / ကသိပ်ဒီး

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