OKLAHOMA State Department of Health

Newborn Screening Program

Religious Tenets and Practices Refusal Form

Infant's Name:_____ Date of Birth:_____ Gender: M / F

Parent/Guardian's Name:_____ Medical Record #:_____

Street Address:_____ Apt/Unit #_____

City/State/Zip:_____ Phone #: _____

Place of Birth (check one): ___Hospital ___ Birthing Facility __ ___Home Birth

Hospital/Facility Name:_____ Attending Physician/Midwife: _____

Child's Dr/Planned Primary Care Provider: _____ Dr's Phone #:_____

Type of Screen Refused: ___Newborn Blood Spot ___Pulse Oximetry Screen ___Hearing Screen
(check any that apply & complete the corresponding section(s) below)

I, (**Guardian's name**) _____, have been fully informed of the importance of newborn screening, and I understand that all newborns are required by law* to have the newborn screening tests performed. Although the benefits of newborn screening and the dangers of not being screened have been explained to me, I elect to refuse the newborn screening test(s) checked above for my child, (**Infant's name**) _____, born on __ __/__ __/__ __, as such testing of my infant conflicts with my religious tenets and practices. My decision was made freely, and I accept the legal responsibility for the consequences of this decision. I have discussed the newborn screening tests with _____ _____, my child's healthcare provider, and I understand the risks to my child if the newborn screen(s) are not completed.

Blood Spot Refusal

I, (**Guardian's name**) _____, understand the disorders included in the newborn metabolic screen test are easily detected by testing a small blood sample from my baby's heel. I am aware that the signs and symptoms of these disorders sometimes do not appear for several weeks or months, and irreversible damage can occur before symptoms become apparent. I have been informed that these conditions are treatable but if left untreated may cause permanent damage to my child, including mental retardation, growth failure, and even death. I also understand that my current declination does not prevent me from later changing my mind and that a blood spot screen can be performed up to 6 months of age.

Pulse Oximetry Refusal

I, (**Guardian's name**) _____, understand the congenital heart defects that the pulse oximetry test screen for can be detected by measuring the amount of oxygen in my baby's blood. I am aware that the signs and symptoms of these defects sometimes do not appear for several weeks or months, and irreversible damage or death can occur if not identified early.

Hearing Refusal

I, (**Guardian's name**) _____, understand the importance of finding out if my baby can hear sounds needed to listen and talk. It has been explained to me that most babies born with hearing loss have parents who can hear and there is no history of hearing loss in their family. I understand that any degree of hearing loss has the potential to interrupt speech, language, cognition, emotional and/or social development. I also understand that my current declination does not prevent me from changing my mind. I also understand that a hearing screen can be performed on my child at any time I choose.

_____ _____ __ __ / __ __ / __ __ __ __
Print Parent/legal Guardian's Name Signature of Parent/Legal Guardian Date

_____ _____ __ __ / __ __ / __ __ __ __
Print Witness Name Signature of Witness Date

**63 O.S. §§ 1-533, 1-534; & 1-543 (2025)*

Directions:
Original Copy to infant's record
Provide copy to parent and healthcare provider
Attach to the blood spot demographic form and send to the Public Health Laboratory or fax/email/mail a copy to the Newborn Screening Program Coordinator:

Oklahoma State Department of Health
Newborn Screening Program Coordinator
123 Robert S. Kerr Ave Ste 1702
Oklahoma City, OK 73102-6406
Fax (405) 900-7556
Email: NewbornScreen@health.ok.gov
Phone (405) 462-8310 or 1-800-766-2223