



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 \_\_/\_\_/\_\_, on that 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 the newborn metabolic screen test for 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.

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.

Print Parent/legal Guardian's Name \_\_\_\_\_ Signature of Parent/Legal Guardian \_\_\_\_\_ Date / \_\_\_/\_\_\_
Print Witness Name \_\_\_\_\_ Signature of Witness \_\_\_\_\_ Date / \_\_\_/\_\_\_

\*under 63 O.S. 2002, Sections 1-533 and 1-534; & 63-1-543

Directions:
Original Copy to infant's record
Provide copy to parent and healthcare provider
Forward copy by fax or mail to OSDH:

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
Phone (405) 462-8310 or 1-800-766-2223