REFUSAL OF NEWBORN SCREENING TESTS

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH-NEWBORN SCREENING PROGRAM
SFN 60025 (1-2012)

Infant's Name	
Medical Record Number	Date of Birth
Place of Birth	
Attending Physician or Practitioner	

- I have received and read the parent information describing newborn screening in North Dakota. I understand that these disorders are easily detected by testing a blood sample from my baby's heel.
- I have been informed and I understand that it is the Law of the State of North Dakota that all newborns shall be screened for these disorders, unless the parents object to the testing.
- I have been informed and I understand, that if untreated, these conditions may cause permanent damage to my child, including serious mental retardation, growth failure, and even death.
- I understand that a copy of this form will be sent to the North Dakota Department of Health within six days after testing was refused by law.
- I have discussed this screening with the above-mentioned physician or practitioner and I understand the risks to my child if this screening is not completed.
- I do not want this infant screened for these disorders.
- My decision was made freely and I accept the legal responsibility for the consequences of this decision.

Parent or Legal Guardian Printed Name	Date
Parent or Legal Guardian Signature	Date
Witness Signature	Date

Original: Infant's Medical Record

Copy: North Dakota Newborn Screening Program
Division of Family Health
North Dakota Department of Health
600 East Boulevard Avenue, Dept. 301
Bismarck, ND 58505-0200

Copy: Parent/Guardian

Fax: 701.328.1412

This form must be submitted (by mail or fax) by the health-care provider within six days after testing was refused.