NEWBORN SCREENING - PARENT REFUSAL FORM

Name of Infant	Hospital of Birth
Date of Birth	Hospital Street Address
Medical Record Number	City/State/Zip

I, _____, have received current information about the Arizona Department
Parent's Name
of Health Services' Newborn Screening Program. I understand there are many rare, inherited disorders for which Arizona newborns are screened.

I have been informed and understand that these tests are offered by State Law for all infants born in Arizona.

I have been informed and understand that, if untreated, these conditions may cause permanent damage to my child, including serious mental retardation, growth failure and, in some cases, death.

I have discussed the testing requirements with_____. I have had the
Healthcare Provider
testing requirements explained to me, and I understand all the risks involved if the screening tests are not given to my child.

I have been informed and understand the nature of the screening tests and how these tests are given.

I object to these tests, and I do not want _____ tested for the conditions at
Child's Name
this time. I understand that I may request the Newborn Screening from my physician at a future date, but no later than my child is one year of age.

My decision was freely made without undue influence or encouragement by any person.

Printed Name	Relationship to Child
Signature	Date
Printed Name of Witness	Witness Title/Address
Witness Signature	Date

Original: Infant's Medical Record
Copies: Newborn Screening Follow-up Program
Parent, Healthcare Provider