Maryland
DEPARTMENT OF HEALTH

*Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary*

**REFUSAL FORM - NEWBORN SCREENING**

| | |
|---|---|
| **Baby's Name** | |
| **Date of Birth** | |
| **Hospital of Birth** | |
| **Medical Record Number** | |

**I understand that:**

The Maryland Department of Health and the American Academy of Pediatrics strongly recommend newborn screening, which is an important part of newborn baby care.

Newborn babies are tested for conditions that cause developmental delays, serious health problems, and, in rare cases, even death. Maryland tests babies for over 60 conditions recommended by national experts. (Health Resources and Services Administration's Recommended Uniform Screening Panel)

Although it is rare, babies in Maryland are found to have one of these conditions each month.

Babies with these conditions usually look healthy. Treatment, if started early, can help to prevent problems.

The State will provide access to treatment for every baby found to have one of the conditions included in the newborn screen.

Testing all babies is important because babies with these conditions usually seem healthy.

The tests are done on a small amount of the baby's blood. The blood is collected by pricking the baby's heel. Only one prick is needed to test for over 60 conditions.

**I _____ am the parent of _____ or legal guardian of _____. I understand that if my baby has one of these disorders and does not have newborn screening, the delay in diagnosis and treatment can result in severe health problems, developmental delay, or even death.**

**I have been provided with information about newborn screening. I know that if I have additional questions, I can contact the Newborn Screening Laboratory at the State Health Department at 443-681-3900 or I can go to the State Laboratory's website at http://dhmh.maryland.gov/laboratories (click on Newborn and Childhood Screening).**

**I have discussed newborn screening with my baby's doctor or nurse,**

_____ _____

Doctor's /Nurse's/Provider's Name Phone Number

**My questions have been answered to my satisfaction.**

**Nevertheless, I do <u>not</u> agree to the collection of a blood sample from my baby for the newborn screening tests.**

**I accept full responsibility for the decision not to permit my baby to have newborn screening performed.**

**I agree to release and hold harmless the Maryland Department of Health and any of its employees, agents or assigns for any injury to, illness, or medical condition of the child named in this form, up to and including the death of said child, caused by a disorder that is screened for under the State's newborn screening comprehensive testing panel. I am hereby refusing that health screening for my child against the recommendation of the Maryland Department of Health.**

| | |
|---|---|
| **Parent/Guardian Name** | |
| **Signature** | |
| **Street Address** | |
| **City, State, Zip** | |
| **Phone Number** | |
| **Phone Number** | |
| **Date** | |
| **Witness Name** | |
| **Witness Signature** | |

**For a list of conditions screened for by Maryland Newborn Screening, please scan the QR code below.**