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INFORMED REFUSAL: NEWBORN SCREENING

I, _____
Parent/legal guardian first and last name

the parent/guardian of baby _____
Circle one Baby's name

born _____ at _____
Date of birth Name of hospital

DO NOT CONSENT TO HAVE MY BABY'S BLOOD TAKEN FOR NEWBORN SCREENING TESTS
 (tests are listed below).

I make this choice knowing that:

- The screening needs only a few drops of blood from my baby's heel.
- The screening is for 22 treatable disorders (listed below).
- My baby can look perfectly normal at birth and still have one of these disorders.
- These disorders can cause severe mental handicap, growth problems, health problems and sudden infant death. When found and treated early, these problems may be prevented or reduced.

Print name of parent/guardian	Signature of parent/guardian	Date
Print name of physician/midwife	Signature of physician/midwife	Date
Print Name of witness	Signature of witness	Date

Newborn Screening Tests			
Metabolic Disorders <i>Amino Acid Disorders:</i> <ul style="list-style-type: none"> • Phenylketonuria (PKU) • Maple Syrup Urine Disease (MSUD) • Citrullinemia (CIT) • Argininosuccinic Acidemia (ASA) • Homocystinuria (Hcy) • Tyrosinemia I (Tyr I) 	<i>Fatty Acid Oxidation Disorders:</i> <ul style="list-style-type: none"> • Medium-chain Acyl-CoA Dehydrogenase Deficiency (MCAD) • Long-chain Hydroxyacyl-CoA Dehydrogenase Deficiency (LCHAD) • Very-long chain AcylCoA Dehydrogenase Deficiency (VLCAD) 	<i>Organic Acid Disorders:</i> <ul style="list-style-type: none"> • Propionic Acidemia (PROP) • Methylmalonic Acidemia (MUT) • Cobalamin Disorders (Cbl A,B) • Glutaric Aciduria Type 1 (GA I) • Isovaleric Acidemia (IVA) 	<i>Galactosemia (GALT)</i>
Endocrine Disorders <ul style="list-style-type: none"> • Congenital Hypothyroidism (CH) • Congenital Adrenal Hyperplasia (CAH) 	Hemoglobinopathies (sickle cell and related disorders)	Cystic Fibrosis (CF)	

- Copies: Baby's health record *and*
- Physician / Midwife *and*
- Newborn Screening Lab Fax: 604-875-3836