Department of Health and Human Services
Maine Center for Disease Control and Prevention
Children with Special Health Needs
Maine Newborn Bloodspot Screening Program
286 Water Street
Augusta, Maine 04333-0011
Tel.: (207) 287-5357; Fax: (207) 287-4743
TTY Users: Dial 711 (Maine Relay)

NEWBORN BLOODSPOT SCREENING REFUSAL

Infant's Name: _____

Date of Birth: _____ Place of Birth: _____

Parent (s) Guardian (s) Name:_____

Address:_____

I/We understand that **Maine law** requires all infants to be tested for conditions that can cause problems such as intellectual and developmental disability, serious illness and even death. Included in this testing are cystic fibrosis, phenylketonuria, hypothyroidism, galactosemia, homocystinuria, MCAD, and maple syrup urine disease. These conditions are easily detected and can be treated to prevent **intellectual and developmental disability and other health problems, which may include problems with growth, breathing problems, eye problems, blood clots, coma or death.**

I/We understand that all infants must be tested except when a parent has a religious objection to the testing. This objection relates to religious beliefs and is not an alternative to testing prior to early discharge.

I/We refuse to have my baby tested because my religious beliefs do not allow it. I have read this information and understand the possible consequences of this decision. I also understand that the **MAINE NEWBORN SCREENING PROGRAM** will be notified of this refusal, as is required by **Maine law.**

Signature: _____ Relationship: _____ Date: _____

Signature: _____ Relationship: _____ Date: _____
(second parent/guardian optional)

Witness: _____ Date: _____

MEDICAL PERSONNEL

I have explained the **Maine law** requiring the newborn screening test, how the tests are done, the meaning of the results, and the possible consequences to this infant of not performing these tests, and have answered any questions the above adults had about the tests. This refusal relates to religious objections and is not an alternative to testing prior to early discharge.

Name: _____ Title: _____
Signature: _____ Date: _____
Name of Child's Doctor: _____
Address: _____

Please forward signed original copy to Maine NBSP, 11 State House Station, Augusta, ME 04333 or fax to 207-287-4743. Retain a copy for the baby's record.