



Refusal Form: Newborn Screening

I, _____, residing at _____, the _____ of
Name Place of residence Parent or guardian

Baby _____ born _____ at _____

Baby's Hospital Number _____

Physician's or Health Provider's name _____

Refuse to have the baby's blood taken for newborn screening tests for inherited metabolic diseases.

I do this in the knowledge that:

- The test requires only a few drops of blood from my baby's heel.
- These tests are for treatable disorders: Such as: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, medium chain Acyl-CoA Dehydrogenase Deficiency (CAD), etc. (see website for a complete list – <https://www.saskhealthauthority.ca/Services-Locations/RRPL/Pages/Screening-and-Reference-Services.aspx#Newborn-Screening>).
- The baby can look perfectly normal at birth and still have these diseases.
- These diseases can cause irreversible brain damage or death, which may be prevented if treated as soon as possible after birth.
- I also understand it is my sole responsibility to notify the hospital where I will give birth of my decision by signing and submitting this form to the newborn's attending physician or midwife.
- I have made this decision in consultation with my physician/health care provider.

Signature of parent/legal guardian: _____

Date: _____

Signature of Witness: _____

Make three copies:

One for file, one for physician/midwife/health care provider, and send the third one to Roy Romanow Provincial Laboratory Fax: (306) 798-3060

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