

Division of Newborn Screening and Genetics

Refusal of Newborn Screening Form

Every baby born in Pennsylvania is required to have a dried blood spot (DBS) screening, a critical congenital heart defect (CCHD) screening and a hearing screening 24 to 48 hours after they are born. These screenings help detect harmful disorders that may cause your baby to stop growing, struggle with mental issues, lead to hearing loss or even lead to an early death.

As a parent or guardian, you can refuse any of these screenings if they are against your religious beliefs or practices. However, choosing not to have your baby screened may cause a delay in treatment if he or she has any of the conditions that these screenings look for. It is important to note that babies with a disorder found by these screenings may look and act like healthy newborns, and delaying treatment can cause permanent damage to your baby.

What is a DBS Screening: A nurse will take a few drops of blood from your baby's heel and put it on a DBS card. That card is then sent to the state contracted laboratory to be tested for harmful disorders that you cannot see when your baby is born.

What is a CCHD Screening: A small, painless pulse oximeter is placed on your baby's finger and foot to make sure that there is enough oxygen in the blood.

What is a Hearing Screening: Different noises, like clicks or soft tones, are played into your baby's ear to find possible hearing loss.

Parent/Guardian Acknowledgement of Refusal for Newborn Screening:

My healthcare provider has educated me, with spoken and written information, about the importance of DBS, CCHD and hearing screenings. I had the chance to discuss the screenings with my healthcare provider. I accept full responsibility for the **potential outcomes, including serious illness, disability or death, associated with refusing newborn screening**. I acknowledge that I have read this document, or it has been read to me. I understand that my signature means that I am refusing the screening checked below for my baby.

I decline screening for: (check all that apply)

☐ DBS Screening
 ☐ CCHD Screening
 ☐ Hearing Screening

Parent/Guardian Signature	Printed Name	Date	
Birth Mother's Name		Guardian's Telephone Number	
Witness Signature	Printed Name	Date	
Name of Baby (First, Middle, Last)		Gender (M, F)	Date of Birth
Parent/Guardian Mailing Address	City	State	ZIP Code
Submitter name			Submitter Code

Please return a signed copy of this form within seven days of the refusal by fax, at 717-724-6995, or mail to:

Pennsylvania Department of Health
 Division of Newborn Screening and Genetics, 7th Floor East
 625 Forster Street
 Harrisburg, PA 17120