IOWA Health and Human Services

Refusal of Newborn Screening for Critical Congenital Heart Disease (CCHD)

INFANT NAME:

DATE OF BIRTH: **TIME OF BIRTH:**

INFANT'S ADDRESS:

PARENT'S ADDRESS:

PARENT'S PHONE NUMBER home or cell (circle one):

PARENT'S EMAIL ADDRESS:

PLACE OF BIRTH (FACILITY NAME):

ATTENDING BIRTH CARE PROVIDER AT BIRTH:

PROVIDER WHO WILL BE OVERSEEING BABY'S WELL-BABY CHECKS:

I have received and read the parent informational brochure which describes the newborn screening for critical congenital heart disease. I understand that some heart disorders may be detected by using a pulse oximeter on my baby's hand and foot, and this test does not harm my baby.

I have been informed, and I understand that it is the law of the state of Iowa that all newborns shall be screened for these disorders.

I have been informed, and I understand that this screening is done to detect these disorders because when symptoms appear the baby may already be in distress.

I have been informed and understand that, if undetected, these conditions may cause permanent damage to my child, including brain damage and death.

I have discussed this screening with _____

(BIRTH CARE PROVIDER)

and I understand the risks to my child if this screening is not completed.

My decision is made freely, and I accept the legal responsibility for the consequences of this decision.

IOWA | Health and Human Services

Reason for refusal (optional): _____

_____

I hereby release, waive, discharge, and covenant not to sue:

_____,

(NAME OF HOSPITAL OR BIRTH CARE PROVIDER)

the Iowa Department of Health and Human Services, the State of Iowa, and all employees, officials, staff, agents, and volunteers of these entities and agencies for any liability, claim, and/or cause of action arising out of my refusal to allow my child's birth care provider to conduct newborn screening for critical congenital heart disease on my baby or arising out of any loss, damage, injury, or illness that occurs as a result of the fact that my baby was not screened for the congenital disorders available in the newborn screening panel.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____

PRINT NAME OF PARENT OR LEGAL GUARDIAN

Return to: NBS Follow-up Program

Email: iowanewbornscreening@uiowa.edu

Fax 319-384-5116

If you need help completing this form or want to request an accommodation, contact access@hhs.iowa.gov. Business hours are Monday-Friday, 8:00 am – 4:30 pm.