New Mexico
Newborn Screening Program
Newborn Screening Test Refusal

_____ _____
Name of Infant (Print) Hospital of Birth/Name of Midwife

_____ _____
Birth Date Street Address

_____ _____
Mother's Name City/State/Zip

1) I have received the Department of Health brochure entitled New Mexico Newborn Screening Tests and Critical Congenital Heart Disease handout, concerning the newborn screening tests for metabolic, endocrine, hemoglobin, hearing and critical congenital heart disorders.
2) I have been informed and I understand that these tests are required by State Law for all infants born in New Mexico.
3) I have been informed and I understand that these tests are given to detect these disorders as babies may look normal and symptoms may not appear for several weeks or months.
4) I have been informed and I understand that untreated, these conditions may cause permanent damage to my child, including serious cognitive impairment, growth failure and in some cases death.
5) I have discussed the testing requirements with _____and I
Name of Health Professional
have had explained, and I understand all the risks involved if these tests are not given to my child.
6) I have been informed and I understand the nature of the tests and how these tests are given.
7) I object to the following screen (s):
_____Newborn Genetic Screen
_____Newborn Critical Congenital Heart Disease
_____Newborn Hearing Screening

and I do not want _____tested for these conditions.
Name of Infant
8) Would you share with us the reason why you chose not to have your baby screened?

_____

My decision was freely made without force or encouragement by my doctor, midwife, hospital personnel, or state officials and I accept the legal responsibility for the consequences of this decision.

Signed _____ Relationship_____
Print _____
Witnessed by _____ Date ____/____/____

Original
Infant's Medical Record

Copy
NM Newborn Screening Program
1190 S. St. Francis Drive
Santa Fe, NM 87505

Copy
Parent/Guardian

Date: 03/15/2024