Notification of Parental Refusal of Dried-Blood-Spot and Critical Congenital Heart Disease Screening

Virginia Department of Health
Division of Child and Adolescent Health
Pediatric Screening and Genetic Services
109 Governor Street, 8th Floor
Richmond, VA 23219

Infant's Name: _____

Infant's Date of Birth: _____

Mother's Name: _____

Address: _____

_____

I, _____, hereby acknowledge that I am the parent or legal guardian of the above named infant. I have been informed of the need for newborn dried-blood-spot screening for all disorders and critical congenital heart disease (CCHD) screening mandated by the *Code of Virginia*. I have also been informed that these disorders could results in intellectual disability, physical dysfunction, or even death if unidentified and untreated. I hereby refuse the screening(s) indicated below, based on the grounds that such tests conflict with my religious practices or tenets.

☐ I refuse dried-blood-spot screening ONLY ☐ I refuse CCHD screening ONLY

☐ I refuse BOTH dried-blood-spot AND CCHD screening

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Witness Date

Attending Physician's Name (print): _____

Address: _____

_____

Phone: _____ Fax: _____

Please mail to the address above or fax a copy of this document to the Virginia Department of Health, Attention: Newborn Screening Services, Fax (804) 864-7807

Retain the original for your records.