NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

Refusal of Diagnostic Testing for Cystic Fibrosis

NEWBORN INFORMATION

Name at Time of Birth: _____
AKA: _____
Date of Birth: _____
Mother's Name: _____
Gender: _____
Hospital of Birth: _____
Medical Record #:_____

I, the undersigned parent or legal guardian of the above infant has made the decision not to have my child tested any further for cystic fibrosis. I understand that my child had a positive newborn screen for cystic fibrosis. I have been advised of the chance that my child has cystic fibrosis and the risks and consequences of refusal of follow-up testing.

I accept the legal responsibility for the consequences of this decision.

Sign: _____ Date: _____

Print: _____

Witnessed by: _____

I have explained the means by which the newborn screening tests are done, the meaning of the results, the possible consequences to this infant of not performing diagnostic testing for cystic fibrosis and have answered any questions the above parent/legal guardian had about these tests.

Medical personnel (signature): _____

Date: _____

Name (print): _____

Title: _____

Send original to:
NEWBORN SCREENING PROGRAM
New York State Department of Health
David Axelrod Institute, 120 New Scotland Ave
Albany, NY 12208
Retain copy for permanent record of this child