



Department of Health

ANDREW M. CUOMO Governor

HOWARD A. ZUCKER, M.D., J.D. Commissioner

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Refusal of Diagnostic Testing for Cystic Fibrosis

NEWBORN INFORMATION:

Name at Time of Birth: _____

Other Names (AKA): _____

Single Birth [] Twin A [] Twin B [] Other _____

Mother's Name: _____

Date of Birth: _____

Gender: Male [] Female []

Hospital of Birth: _____

Medical Record #: _____

I, the undersigned parent or legal guardian of the above infant have 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: _____

Print and send original to: NYS Newborn Screening Program David Axelrod Institute 120 New Scotland Avenue Albany, NY 12208

Retain a copy for this child's permanent record