Oregon State Public Health Labratory

Northwest Regional Bloodspot Screening Program

OREGON HEALTH AUTHORITY

Objection to Newborn Screening Blood Test

I/We, _____ am/are the parents/legal guardian of
Print parent/guardian full name

_____, born on ___/___/_____ at _____.
Child's name MM DD YYYY Facility

1. I/We have had fully explained to me/us the medical benefits of the newborn screening blood test as mandated for all newborns in the State of Oregon by Administrative Rules 333-024-1000 through 333-024-1110.

2. I/We have been informed and understand that this screening is done to detect over 40 disorders where symptoms sometimes do not appear for several weeks or months, and irreversible damage can occur before symptoms become apparent to the family or heath care providers.

3. I/We understand that failure to detect and treat the screened conditions within the first few days or weeks of life can be life threatening or cause significant mental or physical impairments.

4. I/We have been informed and understand that the risk of my infant having one of these conditions is approximately 1 in 250 births.

5. I/We have discussed the testing with _____ RN, PA, NP, MD, DO, Midwife who has explained the risks involved if my child is not screened.

6. I/We have been informed and understand the only legally permissible reason for refusing to have my/our infant screened.

Pursuant to the provisions of the Oregon Administrative Rules 333-024-1050, the undersigned parent or legal guardian of _____ born on _____, states that this child is
Child's name Date
exempt from newborn screening.

_____ _____
Parent or Legal Guardian Signature Date

Original to:
Infant's Medical Record

Copy to:
Oregon NBS Program
PO Box 275
Portland, OR 97207-0275

Copy to:
Parent/Legal Guardian
PCP: _____

7202 NE Evergreen Parkway Suite 100, Hillsboro, Oregon, 97124
Voice: (503) 693-4174 | Fax: 503-693-5601
All relay calls accepted| https://www.oregon.gov/oha/ph/laboratoryservices/newbornscreening