Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
286 Water Street
Augusta, Maine 04333-0011
Tel; (207) 287-8016; Fax (207) 287-9058
TTY: Dial 711 (Maine Relay)

Maine CDC Children and Youth with Special Health Needs Program

CRITICAL CONGENITAL HEART DEFECTS SCREENING REFUSAL

INFANT'S NAME: _____Sex; Male/Female

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

PARENT (S)/GUARDIAN (S) NAME: _____

ADDRESS: _____

I/We understand that **Maine law** requires all infants to be tested for Critical Congenital Heart Defects (CCHD) using pulse oximetry to measure the oxygen in the blood. Low oxygen levels in the blood may indicate serious heart defects or other problems. The screening test may detect seven specific heart defects that may not cause signs until after the first few days of life. Some babies with CCHD may develop fast, difficult breathing, grunting sounds with breaths, bluish color of lips, poor eating, or extreme sleepiness. These heart defects can cause sudden critical heart problems that could cause death. It is possible that a baby with a heart problem may have a normal screening test.

I/We understand that all infants must be tested except when a parent has a religious objection to the testing. This objection relates to religious beliefs only and is not an alternative to testing prior to early discharge.

I/We refuse to have my baby tested because my religious beliefs do not allow it. I have read this information and understand the possible consequences of this decision. I also understand that the **MAINE CDC CHILDREN AND YOUTH WITH SPECIAL HEALTH NEEDS PROGRAM** will be notified of this refusal, as is required by **Maine law.**

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____
(second parent/guardian optional)

WITNESS: _____ DATE: _____

MEDICAL PERSONNEL

*I have explained the **Maine law** requiring the CCHD screening test, how the test is done, the meaning of the results, and the possible consequences to this infant of not performing this test, and have answered any questions the above adults had about the test. This refusal relates to religious objections and is not an alternative to testing prior to early discharge.*

NAME: _____

TITLE: _____ DATE: _____

SIGNATURE: _____

NAME OF CHILD'S DOCTOR: _____

ADDRESS: _____

Please forward signed original copy to Maine CYSHN, 11 State House Station, Augusta, ME 04333 or fax to 207-287-4743.
Retain a copy for the baby's record.