Affix Patient Label	
Patient Name:	DOB:

Informed Consent to Refuse Standard Newborn Treatments and Tests

This information is given to you so that you can make an informed decision about **refusing standard newborn treatments and tests.** There are eight treatments or tests on this form.

The newborn treatments and tests listed below are recommended to you and your baby based on the most recent and best available evidence.

You can decide which treatments or tests you do not want. Refusing one treatment or test does not mean that everything must be refused.

Reason and Purpose of Standard Newborn Treatments:

To prevent, treat and screen newborns for problems that could impact the baby's health.

Benefits of Standard Newborn Treatments:

Your baby might receive the following benefits. Your doctor cannot promise your baby will receive any of these benefits. Only you can decide if the benefits are worth the risk.

Risks of Standard Newborn Treatments:

No treatment is completely risk free. Some risks are well known. There may be risks not included in this list that may not be expected.

Treatment	Benefits of Treatment	Risks of Treatment	Risks of Refusing Treatment
Vitamin K Shot	Prevent bleeding problems in newborns	Pain of needle stick	Bleeding in the brain causing permanent disability or death
Erythromycin Eye Ointment	Prevent eye infections (required by Michigan law)	Temporary blurring of vision from ointment	Eye infection that could cause blindness
Hearing Screen	Identification of hearing loss (required by Michigan law)	None	Delays in speech and learning if baby has hearing loss
Newborn Screen	Identification of more than 50 conditions(required by Michigan law)	Slight pain and possible bruising at blood draw location	Undiagnosed disease(s) which could lead to mental and physical disabilities or death
Congenital Heart Screen	Early recognition of heart defects (required by Michigan law)	None	Delay in diagnosis of heart defect which could lead to death

Treatment	Benefits of Treatment	Risks of Treatment	Risks of Refusing Treatment
Hepatitis B vaccine	Prevents infection from Hepatitis B virus	Soreness at injection site and possible mild fever	Illness that could lead to liver damage, liver cancer or death.
Bilirubin level	Ability to manage high bilirubin levels more quickly	Discomfort and possible bruising at blood draw location	High bilirubin levels that could lead to permanent brain damage
Angle Tolerance Test (if applicable)	Ability to check newborn's breathing in car seat position	None	Baby may not be able regulate breathing while in a car seat. This could cause episodes of not breathing and/or death.

I understand that if I refuse offered services, I am doing so against medical advice and State of Michigan laws. I understand that my refusal may result in a worsening of my child's condition. My refusal could pose a threat to his/her life, health and medical safety.

By signing this form, I agree that I am responsible for all of the risks and consequences of my refusal. I agree that Bronson Healthcare Group (BHG), as well as BHG officers, employees, agents and any other individuals participating in the care of my child are not responsible for claims, damages, or legal liabilities arising from my refusal to consent to any or all standard newborn treatments listed on this form.

I hereby **REFUSE** the following offered treatments for my child (as initialed below):

__Vitamin K shot
__Erythromycin eye ointment
__Hearing screen
__Newborn screen
__Congenital heart screening
__Hepatitis B Vaccine
__Bilirubin Level
__Angle Tolerance Test

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor or advanced practice provider. My questions have been answered.

(Signature of one parent/guardian required – signature of both preferred)

____ ________________
Signature of parent/guardian (Printed name) Date/Time

____ ________________
Signature of parent/guardian (Printed name) Date/Time

____ ________________
Signature of witness (Printed name) Date/Time

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

____________________________________ _______________ ________________
Interpreter (if applicable) *Date* *Time*

For provider use only:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options and possibility of complications and side effects of the intended intervention. I have answered questions and parent/guardian has agreed to treatment.

Provider or Advanced
Practice Provider Signature_________________________________ **Date**____________ **Time**__________