METABOLIC AND HEMOGLOBIN SCREENING NOTICE

I, the parent of Baby _____, understand that Georgia law requires that all infants born in Georgia have the Newborn Screening test performed, unless the parent's object to such testing for religious reasons.

The Newborn Screening Test, which tests for a number of inherited disorders, involves the collection of blood obtained by pricking the heel of the baby's foot. Temporary pain might be experienced during the collection procedure. The inherited disorders are galactosemia, maple syrup urine disease, homocystinuria, phenylketonuria, tyrosinema, hypothroidism, congenital adrenal hyperplasia and hemoglobin disorders as of October 1, 1998.

I understand that if the Newborn Screening Test detects one of these inherited disorders, appropriate treatment may be provided and irreparable injury or death may be prevented. If one or more of these disorders exists but is not detected, mental retardation, physical handicaps or death may result. I understand that this test does not check for all genetic disorders.

I understand that the Newborn Screening Test described above must be performed when the infant is at least 48 hours old and has been taking protein feeding (formula or breast milk) for at least 24 hours. If an infant is discharged prior to that time, Georgia law requires that the infant be tested on discharge and that the test be repeated before one week of age. If the infant is taking an antibiotic, mark yes on the form and write in the name of the antibiotic.

IF MY CHILD IS DISCHARGED FROM THE HOSPITAL BEFORE HE OR SHE IS 48 HOURS OLD OR HAS HAD PROTEIN FEEDING FOR 24 HOURS, I UNDERSTAND THAT I AM RESPONSIBLE FOR ARRANGING FOR THE FOLLOW-UP TEST PRIOR TO ONE WEEK OF AGE. I UNDERSTAND THAT THIS TEST CAN BE PERFORMED AT MY CHILD'S DOCTOR'S OFFICE, A HEALTH DEPARTMENT CLINIC, OR AT THE HOSPITAL LABORATORY.

I acknowledge that I have received and understand the above information about the Newborn Screening Test and that I have been given an opportunity to ask questions and receive additional information and an opportunity to refuse the test, if I object for religious reasons.

_____	_____	_____
Parent(s)	Date	Time
_____	_____	_____
Witness	Date	Time