WYOMING DEPARTMENT OF HEALTH
NEWBORN METABOLIC SCREENING
CONSENT/WAIVER FORM

Infant's Name _____

Date of Birth _____

Mother's Name _____

Address _____

_____

Phone Number _____

I authorize the screening of my infant for metabolic disorders. I have read and understand the information packet on Infant Metabolic Screening and understand the nature and purpose of the test. I know that a metabolic screening may be obtained by having a blood sample taken by a physician, hospital personnel, public/private medical laboratory, or a local public health nurse. I am aware that there may be a charge assessed which may or may not be covered by insurance, I agree to pay for the screening if it is not covered by insurance. I understand that this information will be use to ensure that appropriate and timely medical services are made available to my child.

_____ _____
Signature Date

_____ _____
Relationship to Infant Witness

I do not authorize the screening of my infant for metabolic disorders. I have read and fully understand the information packet on Infant Metabolic Screening and accept responsibility for choosing not to have this screening performed.

_____ _____
Signature Date

_____ _____
Relationship to Infant Witness

The completed consent/waiver forms should be returned to:

The Wyoming Early Hearing Detection and Intervention Program
1771 Centennial Drive, Suite 220
Laramie, WY 82070
Fax: 307-721-6313

WYOMING DEPARTMENT OF HEALTH
NEWBORN HEARING SCREENING
CONSENT/WAIVER FORM

Infant's Name _____

Date of Birth _____ Male _____ Female _____

Mother's Name _____ Phone Number _____

Father's Name _____ Phone Number _____

I authorize the screening of my infant for hearing loss. I have read and understand the information packet on Infant Hearing Screening and understand the nature and purpose of the test. I have received the list of hospitals and child development centers where I may obtain a hearing screening for my infant. I am aware that there may be a charge assessed by the hospitals which may or may not be covered by insurance, I agree to pay for the screening if it is not covered by insurance. I am also aware that the hearing screening is free of charge if obtained at a child development center. I understand that this information will be used to ensure that appropriate and timely medical, educational, and audiological services are made available to my child.

_____ _____
Signature Date

_____ _____
Relationship to Infant Witness

Newborn Hearing Screening Results

Initial Hearing Screening Date: _____

Left Ear: PASS _____ FAIL _____ Right Ear: PASS _____ FAIL _____

Rescreening Date (if necessary): _____

Left Ear: PASS _____ FAIL _____ Right Ear: PASS _____ FAIL _____

Risk factors for Late Onset Hearing Loss (please check all that apply)

_____ Family History of Childhood Hearing Loss
_____ Syndrome Associated with Hearing Loss
_____ Ototoxic Medication
_____ Severe Asphyxia at Birth
_____ Craniofacial Anomalies
_____ Perinatal Infection
_____ Low Birth Weight
_____ Prolonged Ventilation
_____ Hyperbilirubinemia
_____ Bacterial Meningitis

I do not authorize the screening of my infant for hearing loss. I have read and fully understand the information packet on Infant Hearing Screening and accept responsibility for choosing not to have this screening performed.

_____ _____
Signature Date

_____ _____
Relationship to Infant Witness

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The Wyoming Early Hearing Detection and Intervention Program
1771 Centennial Drive, Suite 220
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Name of Midwife Reporting Results _____ Date: _____