# Critical Congenital Heart Defects (CCHD) Screening Consent

**Infant's Name**

**Date of Birth**

**Medical Record Number**

## Information Provided

I have received information about the CCHD screening and have had the opportunity to ask questions.

## Consent

☐ I consent to CCHD screening for my infant. ☐ I do NOT consent to CCHD screening for my infant.

**Parent/Guardian Name**

**Signature**

**Date**

**Healthcare Provider Name**

**Signature**

**Date**

**Notes**