



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
FAMILY HEALTH AND WELLNESS
NEWBORN SCREENING PROGRAM
710 James Robertson Parkway 8th Floor Nashville, TN 37243
Phone (615) 532-8462 Toll Free: (855) 202-1357 Fax (615) 532-8555

NEWBORN SCREENING REFUSAL FORM

Instructions: Fill out a Newborn Screening filter card with the following information and attach this completed and signed refusal form.

- | | |
|---|--|
| a. Marked 'Refused' as reason for NO BLOOD SCREEN | d. Hospital of Birth ID |
| b. Infant first and last name | e. Mother first and last name |
| c. Infant date and time of birth | f. Mother address, city, state and zip |

If parents also refuse the hearing screen and CCHD screen, please mark as appropriate in those boxes at the bottom of the Newborn Screening filter card.

Baby's First and Last Name: _____

Baby's Date of Birth: _____ Time of Birth: _____

Hospital of Birth: _____

Mother's First and Last Name: _____

Mother's Street Address: _____

City: _____ ST: _____ Zip: _____

Mark screens that will not be completed:

- Blood Specimen Screen Hearing Screen Critical Congenital Heart Disease Screen

I, _____, have been informed of the need for a newborn hearing screen, a pulse oximetry screen to detect critical congenital heart disease, and a blood test to screen for metabolic/genetic disorders as designated by the Department of Health.

I have been informed state law requires these tests and that violation of the blood test is a misdemeanor. Nonetheless, I refuse this test at this time for my newborn baby, _____ because such tests conflict with my religious tenets and practices. Under penalty of perjury pursuant to T.C.A. 68-5-403, I affirm such refusal because of a conflict with my religious tenets and practices.

Parent Signature: _____ Date: _____/_____/_____

Witness Signature: _____ Date: _____/_____/_____

Submitted by: _____ Title: _____

This form shall also be retained in the medical record for the period of time defined by the hospital or provider policy.