TENNESSEE NEWBORN SCREENING PROGRAM

NOTIFICATION OF INFANT DEATH

Instructions: Please complete the following form and return via fax or email to: 615-532-8555 or NBS.Health@tn.gov.

Hospital of Birth Information

Hospital/Facility Code: ____________________ **Hospital/Facility Name:** ______________________________________

Hospital of Death Information

Hospital/Facility Code: ____________________ **Hospital/Facility Name:** ______________________________________

Notifying Person: ____

Infant's Information

Infant's First Name: _________________________________ **Infant's Last Name:** __________________________________

Single Birth: _________ **Twin A or B:** _________ **Other:** _________

Date of Birth: _______________________________________ **Time of Birth:** _______________________________________

Date of Death: ______________________________________ **Time of Death:** ______________________________________

Was a newborn screen collected on this infant?

If yes, please provide date and time of collection. ____

Mother's Information

Mother's First Name: ________________________________ **Mother's Last Name:** _________________________________

Mother's Address: ____

City: ______________________________________ **State:** ________________________ **Zip Code:** _______________________

Tennessee Department of Health Newborn Screening Program
Lab Phone: 615-262-6473
Follow-Up Phone: 615-532-8462
Follow-Up Fax: 1-615-532-8555
NBS.Health@tn.gov

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