**Tennessee Department of Health**

**Newborn Screening Follow Up Program**

**Division of Family Health and Wellness**

**R.S. Gass Building, 1st Floor**

**630 Hart Lane, Nashville, TN 37243**

**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.**

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