NEWBORN SCREENING REFUSAL FORM

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

- Marked ‘Refused’ as reason for NO BLOOD SCREEN;
- Infant first and last name;
- Infant date and time of birth;
- Hospital of Birth ID;
- Mother first and last name;
- 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.

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby’s First and Last Name</td>
<td>____________________________</td>
</tr>
<tr>
<td>Baby’s Date of Birth</td>
<td>_______________ Time of Birth: __________</td>
</tr>
<tr>
<td>Hospital of Birth</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>Mother’s First and Last Name</td>
<td>____________________________________________</td>
</tr>
<tr>
<td>Mother’s Street Address</td>
<td>______________________________________________________________________</td>
</tr>
<tr>
<td>City</td>
<td>__________________ ST:______ Zip: __________</td>
</tr>
</tbody>
</table>

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.