MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF GENETICS AND HEALTHY CHILDHOOD

Critical Congenital Heart Disease (CCHD) Reporting Form

Instructions: Please complete the information below and submit to the Department of Health and Senior Services by one of the following methods:
Mail – Bureau of Genetics and Healthy Childhood, PO Box 570, Jefferson City, MO 65109 **or** Fax – 573-751-6185

DEMOGRAPHIC INFORMATION

NEWBORN'S NAME (LAST, FIRST)	DATE OF BIRTH	GENDER	BIRTH ORDER (A-F OR S = SINGLE)	NEWBORN'S MEDICAL RECORD NUMBER
	_ _/_ _/_ _ _ _	☐ MALE ☐ FEMALE		

MOTHER'S NAME (LAST, FIRST)	NEWBORN'S BIRTH LOCATION	NAME OF HOSPITAL, BIRTHING CENTER, AMBULATORY SURGICAL CENTER, OR MIDWIFE
	☐ HOSPITAL ☐ BIRTHING CENTER ☐ HOME ☐ AMBULATORY SURGICAL CENTER ☐ OTHER _____	

MOTHER'S STREET ADDRESS/P.O. BOX	CITY	STATE	ZIP CODE

FIRST CCHD SCREENING RESULT

First Screen Completed? ☐ Yes ☐ No

If Yes

Date of First Screen _ _/_ _/_ _ _ _

Time of First Screen _ _:_ _ A.M. P.M.

SpO2 Right Hand _____%

SpO2 Foot _____%

First Screening Outcome:
- ☐ Pass *(screening complete)*
- ☐ Repeat Screen in 1 hour →
- ☐ Fail (**refer for immediate evaluation**)

If No

Not Screened due to:
- ☐ CCHD diagnosed prenatally
- ☐ CCHD diagnosed clinically at birth
- ☐ CCHD ruled out by echocardiogram
- ☐ Transferred prior to screening
- ☐ Parents refused screening
- ☐ Expired
- ☐ Other _____

SECOND CCHD SCREENING RESULT

Second Screen Completed? ☐ Yes ☐ No

If Yes

Date of Second Screen _ _/_ _/_ _ _ _

Time of Second Screen _ _:_ _ A.M. P.M.

SpO2 Right Hand _____%

SpO2 Foot _____%

Second Screening Outcome:
- ☐ Pass *(screening complete)*
- ☐ Repeat Screen in 1 hour →
- ☐ Fail (**refer for immediate evaluation**)

If No

Not Screened due to:
- ☐ Low value on previous screen/Referred for evaluation
- ☐ Passed previous screen
- ☐ CCHD ruled out by echocardiogram
- ☐ Transferred prior to screening
- ☐ Parents refused screening
- ☐ Expired
- ☐ Other _____

THIRD CCHD SCREENING RESULT

Third Screen Completed? ☐ Yes ☐ No

If Yes

Date of Third Screen _ _/_ _/_ _ _ _

Time of Third Screen _ _:_ _ A.M. P.M.

SpO2 Right Hand _____%

SpO2 Foot _____%

Third Screening Outcome:
- ☐ Pass *(screening complete)*
- ☐ Fail (**refer for immediate evaluation**)

If No

Not Screened due to:
- ☐ Low value on previous screen/Referred for evaluation
- ☐ Passed previous screen
- ☐ CCHD ruled out by echocardiogram
- ☐ Transferred prior to screening
- ☐ Parents refused screening
- ☐ Expired
- ☐ Other _____

FINAL DISPOSITION

Echocardiogram completed? ☐ Yes ☐ No ☐ Unknown

Newborn transferred to referral hospital? ☐ No ☐ Yes, newborn was transferred to _____

Status:
- ☐ Within Normal Limits
- ☐ Unknown
- ☐ Delayed Transition
- ☐ Critical Congenital Heart Disease
- ☐ Non-Critical Congenital Heart Disease
- ☐ Pneumonia
- ☐ Other respiratory condition
- ☐ Sepsis
- ☐ Other _____