



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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH ORDER (A-F OR S = SINGLE)
MOTHER'S NAME (LAST, FIRST)	NEWBORN'S BIRTH LOCATION <input type="checkbox"/> HOSPITAL <input type="checkbox"/> BIRTHING CENTER <input type="checkbox"/> HOME <input type="checkbox"/> AMBULATORY SURGICAL CENTER <input type="checkbox"/> OTHER _____		NEWBORN'S MEDICAL RECORD NUMBER
MOTHER'S STREET ADDRESS/P.O. BOX		CITY	STATE      ZIP CODE
FIRST CCHD SCREENING RESULT	SECOND CCHD SCREENING RESULT	THIRD CCHD SCREENING RESULT	
First Screen Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Second Screen Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Third Screen Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes Date of First Screen _/_/____ Time of First Screen __:__:__ A.M. P.M. SpO2 Right Hand _____% SpO2 Foot _____% First Screening Outcome: <input type="checkbox"/> Pass (screening complete) <input type="checkbox"/> Repeat Screen in 1 hour → <input type="checkbox"/> Fail (refer for immediate evaluation)	If Yes Date of Second Screen _/_/____ Time of Second Screen __:__:__ A.M. P.M. SpO2 Right Hand _____% SpO2 Foot _____% Second Screening Outcome: <input type="checkbox"/> Pass (screening complete) <input type="checkbox"/> Repeat Screen in 1 hour → <input type="checkbox"/> Fail (refer for immediate evaluation)	If Yes Date of Third Screen _/_/____ Time of Third Screen __:__:__ A.M. P.M. SpO2 Right Hand _____% SpO2 Foot _____% Third Screening Outcome: <input type="checkbox"/> Pass (screening complete) <input type="checkbox"/> Fail (refer for immediate evaluation)	
If No Not Screened due to: <input type="checkbox"/> CCHD diagnosed prenatally <input type="checkbox"/> CCHD diagnosed clinically at birth <input type="checkbox"/> CCHD ruled out by echocardiogram <input type="checkbox"/> Transferred prior to screening <input type="checkbox"/> Parents refused screening <input type="checkbox"/> Expired <input type="checkbox"/> Other _____	If No Not Screened due to: <input type="checkbox"/> Low value on previous screen/Referred for evaluation <input type="checkbox"/> Passed previous screen <input type="checkbox"/> CCHD ruled out by echocardiogram <input type="checkbox"/> Transferred prior to screening <input type="checkbox"/> Parents refused screening <input type="checkbox"/> Expired <input type="checkbox"/> Other _____	If No Not Screened due to: <input type="checkbox"/> Low value on previous screen/Referred for evaluation <input type="checkbox"/> Passed previous screen <input type="checkbox"/> CCHD ruled out by echocardiogram <input type="checkbox"/> Transferred prior to screening <input type="checkbox"/> Parents refused screening <input type="checkbox"/> Expired <input type="checkbox"/> Other _____	
FINAL DISPOSITION			
Echocardiogram completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Status: <input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Pneumonia	
Newborn transferred to referral hospital? <input type="checkbox"/> No <input type="checkbox"/> Yes, newborn was transferred to _____		<input type="checkbox"/> Unknown <input type="checkbox"/> Other respiratory condition <input type="checkbox"/> Delayed Transition <input type="checkbox"/> Sepsis <input type="checkbox"/> Critical Congenital Heart Disease <input type="checkbox"/> Other _____ <input type="checkbox"/> Non-Critical Congenital Heart Disease	

# Critical Congenital Heart Disease Screening Table

Right Hand	Either Foot											
100	100	99	98	97	96	95	94	93	92	91	90	<90
99	100	99	98	97	96	95	94	93	92	91	90	<90
98	100	99	98	97	96	95	94	93	92	91	90	<90
97	100	99	98	97	96	95	94	93	92	91	90	<90
96	100	99	98	97	96	95	94	93	92	91	90	<90
95	100	99	98	97	96	95	94	93	92	91	90	<90
94	100	99	98	97	96	95	94	93	92	91	90	<90
93	100	99	98	97	96	95	94	93	92	91	90	<90
92	100	99	98	97	96	95	94	93	92	91	90	<90
91	100	99	98	97	96	95	94	93	92	91	90	<90
90	100	99	98	97	96	95	94	93	92	91	90	<90
<90	<90	<90	<90	<90	<90	<90	<90	<90	<90	<90	<90	<90

**Pass:** 95% or higher in the right hand and either foot AND a difference of 3% or less between the right hand and either foot.

**Repeat Screen:** 90-94% in the right hand and either foot or a difference of 4% or more between the right hand and either foot. Repeat screening in one hour. If third screen is still in the yellow, it is a fail and should be reported to the physician.

**Fail:** 89% or lower in the right hand or either foot (at any time) OR if the third screen is 90-94% in the right hand and either foot or a difference of 4% or more between the right hand and either foot. Failed screenings should always be reported to the physician.