Please fax to Newborn Screening Follow UP: 785-559-4245

CCHD REPORTING FORM

Name of **FACILITY**:_____

INFANT'S Name: (Last)_____ (First)_____

Date Of Birth:_____ Time of Birth:_____(MILITARY FORM)

MOTHER'S Name: (Last)_____(First)_____

Address:_____Phone Number: (_____)_____

Was Screening Completed: ☐ YES ☐ NO **How Many Screenings Were Completed:** ☐ 1, 2, or 3

Date of **Final** Screening: _____**Time** of **Final** Screening: _____ (MilitaryTime)

FINAL SCREENING RESULTS:

Right Upper Extremity (RUE):_____%

Foot:_____% ☐ PASS ☐ FAIL

Difference (RUE – Foot):_____%

***PLEASE RECORD ALL SCREENING RESULTS IF RESCREEN WAS NEEDED.**

Date of **First** Screening: _____**Time** of **First** Screening: _____ (Military Time)

Right Upper Extremity (RUE):_____% Foot:_____%

Difference (RUE – Foot):_____% ☐ PASS ☐ FAIL ☐ RESCREEN

Date of **Second** Screening: _____**Time** of **Second** Screening: _____(Military Time)

Right Upper Extremity (RUE):_____% Foot:_____%

Difference (RUE – Foot):_____% ☐ PASS ☐ FAIL ☐ RESCREEN

Date of **Third** Screening: _____**Time** of **Third** Screening: _____ (Military Time)

Right Upper Extremity (RUE):_____% Foot:_____%

Difference (RUE – Foot):_____% ☐ PASS ☐ FAIL

REFERRED TO CARDIOLOGIST OR FACILITY: ☐ YES ☐ NO ☐ UNKNOWN

FACILITY REFERRED TO:_____**NAME OF CARDIOLOGIST:**_____

REASON FOR NOT SCREENING: ☐ DECEASED ☐ DISCHARGED PRIOR TO 24 HRS ☐ TRANSFERRED TO NICU

☐ DID NOT CONSENT ☐ TRANSFERRED TO ANOTHER HOSPITAL ☐ PRENATAL DIAGNOSIS ☐ OXYGEN

☐ OTHER_____

SCREENING COMPLETED BY:_____

CCHD FORM-REV. 11/2014

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