# State of Connecticut Department of Public Health
# Critical Congenital Health Disease Reporting Form

Baby's Last Name:___________________ DOB:__________ Accession #:____________ Sex:_____Birth Sequence: ______

Mother's Last Name:___________________________Mother's First Name:___________________

Birth Hospital:__________________________ Medical Record #:____________________

Was the newborn screened for critical congenital heart disease? ☐ Yes ☐ No

**If No is selected**, please complete the following the below box:

Why was the newborn not screened for CCHD? Must select one of the options: ☐ Deceased ☐ Not Tested ☐ Refused ☐ Echocardiogram ☐ other, if selected specify____________________☐ Exempt for being hospitals in NICU >30 days

**You are now finished, please fax form to DPH**

**If Yes is selected**, please complete the following (note a baby can have up to 3 screenings to pass):

Date of Screening 1 (MM/DD/YYYY)____________________ Time of Screening 1 (hhmm military time) ________

Screeners First Name________________________________ Screeners Last Name __________________________

Screening Facility ____________________________________________ Unit _____________________

Pulse Ox Saturation of Right Hand (%) ________

Pulse Ox Saturation of Foot: ☐ right foot ☐ left foot Pulse Ox Saturation of Foot (%)______________ Diff % __________

Screening Results: ☐ Pass ☐ Retest ☐ Fail

**If Pass, you are now finished, please fax form to DPH; If Retest, complete the next section**

**If fail explain action taken by Doctor**

**Screening 2 status: Must check one box**

☐ Screened ☐ Deceased ☐ Not Tested ☐ Refused ☐ Echocardiogram ☐ other, if selected specify __________

Date of Screening 2 (MM/DD/YYYY)____________________ Time of Screening 2 (hhmm military time) ________

Screeners First Name________________________________ Screeners Last Name __________________________

Screening Facility ____________________________________________ Unit _____________________

Pulse Ox Saturation of Right Hand (%) ________

Pulse Ox Saturation of Foot: ☐ right foot ☐ left foot Pulse Ox Saturation of Foot (%)______________ Diff %__________

Screening Results: ☐ Pass ☐ Retest ☐ Fail

**If Pass, you are now finished, please fax form to DPH; If Retest, complete the next section;**

**If fail explain action taken by Doctor**

**Screening 3 status: Must check one box**

☐ Screened ☐ Deceased ☐ Not Tested ☐ Refused ☐ Echocardiogram ☐ other, if selected specify _________

Date of Screening 3 (MM/DD/YYYY)____________________ Time of Screening 2 (hhmm military time) ________

Screeners First Name________________________________ Screeners Last Name __________________________

Screening Facility ____________________________________________ Unit _____________________

Pulse Ox Saturation of Right Hand (%) ________

Pulse Ox Saturation of Foot: ☐ right foot ☐ left foot Pulse Ox Saturation of Foot (%)______________ Diff %__________

Screening Results: ☐ Pass ☐ Retest ☐ Fail

**If Pass, you are now finished, please fax form to DPH;**

**If fail explain action taken by Doctor**______________________________________________________________________

**If you are a read only and cannot enter this information into the Maven Newborn Screening System,**
**Fax to: Department of Public Health, Attn: Alessandra Bogacki CFHPS Section at 860-509-7720** (08/2023)