Connecticut Newborn Screening Program

Connecticut Department of Public Health
Dr. Katherine A. Kelley State Public Health Laboratory
395 West Street, PO Box 1689, Rocky Hill, CT 06067

Home Birth, Out of Hospital or Out of State Birth Notification

Please fax this form to (860) 730-8385 or submit with Blood Spot Specimen to State Laboratory

Screening Specimen Collection Recommendations

The CT NBS Program now screens for over 60 disorders*. The addition of new disorders and testing platforms and the timeliness recommendations made by the US Department of Health and Human Services' Advisory Committee for Heritable Disorders in Newborns and Children have led to a ***change in CT NBS Program recommendations.*** The CT NBS Program recommends that the first specimen be collected within 24 to 48 hours after birth, preferably as close as possible to 30 hours of life. We also recommend that specimens are shipped as soon as possible after drying, preferably within 24 hours of collection. **Please call the CT Newborn Screening Program at 860-920-6628 with questions or for NBS supplies**.

**Please note: the CT Newborn Screening Program does not screen for Cystic Fibrosis (CF). Cystic Fibrosis screening is currently performed by either the Yale CF Laboratory, 203-688-9884, or the UCONN CF Laboratory, 860-679-4439, and requires submission of a separate blood spot specimen. Please contact the appropriate CF testing laboratory for testing supplies and more information.*

Infant's Name: (First)_____(Last)_____

Date of Birth**:** _____Time of Birth: _____ (military time) Birth Length: _____ (##. ## (cm)

Head Circumference: _____ (##. ## cm) **(on day 1, take the head circumference 3 times and select the largest measurement to the nearest 0.1 cm)**

Birth Weight: _____Infant's Gender: _____Gestational age: _____Weeks, _____Days

Birth Sequence: _____If Multiple birth, Indicate birth order: _____

Birth Mother's Name: (First)_____(Last)_____

Mother's DOB: _____Street Address: _____

City: _____State_____ Zip:_____

Phone: (H)_____(C)_____

Was the mother tested for HIV during Pregnancy? ☐**Yes** ☐**No**

Is Birth Mother Legal Guardian? ☐**Yes** ☐**No** If No, complete *Legal Guardian Demographic* Section

Legal Guardian Demographic Information

☐**Traditional Surrogate** ☐**Gestational Agreement** ☐**Placed for Adoption** ☐**DCF Legal** ☐**Other**

If Other is Selected, please specify**:** _____

First Name: _____ Last Name: _____

Date of Birth: _____ Street Address: _____City: _____

State:_____ Zip: _____Phone: (H)_____(C)_____

Will this infant be moving out of the country in the next three months? ☐**Yes**☐ **No** If Yes, please provide contact information for someone we can report Newborn Screening results to.

First Name: _____Last Name: _____Relation to Child_____

Street Address: _____City:_____

State/Province/ Region: _____Zip/Postal Code: _____Phone: _____

Connecticut State Statutes

Connecticut General Statute **(CGS) 19a-55** and Connecticut Department of Public Health (CT DPH) regulation **19a-55-1**, require those providing medical care of newborn infants to collect a blood spot specimen for the purpose of screening for genetic, metabolic, endocrine, hematologic and immunologic disorders as prescribed by the CT DPH.

CGS 19a-55 and 19a-59 requires all infants to undergo hearing screening as soon as possible after birth and the cytomegalovirus (CMV) testing for any infant who fails the hearing screening.

CGA 19a-55 requires cystic fibrosis (CF) and critical congenital heart disease (CCHD) screenings, and that an HIV test to be administered to every infant, unless the mother has had an HIV-related test pursuant to section 19a-90 or 19a-593.

CGS 19a-53 and the Clinical Laboratory Improvement Act (CLIA) require that patient demographic information be submitted to the CT DPH Newborn Screening and the CT Birth Defects Registry for all babies born/residing in the state.

CGS 19a-53 requires licensed health care professionals who provide care or treatment to a child that is under the age of one and was born in the CT and who observes or acquires knowledge that the child has a birth defect to notify DPH of the defect within forty-eight hours of observing or acquiring knowledge of the defect.

If an individual attending the infant's birth in the home cannot meet any of these requirements, the parent must be directed to consult with the infant's selected primary medical care provider, either prior to birth or as soon as possible after birth, in order to be compliant with CT State Statutes.

Office Use Only

Date: _____

Accession #: _____

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Infant's Name: _____ **Date of Birth:** _____

Birth Attendant's Name (or name of birth hospital, if born out of state): _____

Primary Care Provider's Name:_____ Practice Name:_____

Phone: _____ Fax: _____ City& State: _____

Birth Defect, Zika and Critical Congenital Heart Disease (CCHD) Screening – Call 860-509-8074 with Questions

Does this child have a birth Defect? ☐**Yes** ☐**No**

If Yes, Please Specify:_____ ICD code: _____

- Did **only** the Mother travel to an area with risk of Zika virus transmission during pregnancy or 2 months prior to pregnancy? ☐ **Yes** ☐ **No**
  - If yes, specify where exposure occurred: _____
- Did the Mother have any male sexual partner(s) and **only** he traveled to any area with risk of Zika virus transmission during pregnancy or 6 months prior to Conception? ☐ **Yes** ☐ **No**
  - If yes, specify where exposure occurred: _____
- Did the mother **and** her male partner travel to an area with risk of Zika virus transmission during pregnancy or 6 months prior to conception? ☐ **Yes** ☐ **No**
  - If yes, specify where exposure occurred: _____

Critical Congenital Heart Disease (CCHD) Screening

Effective 01/15/2018, results of CCHD are to be sent to CT DPH Birth Defects Registry

Date of CCHD screening: _____ Time of Screening (Military Time):_____

If screening was not done, please state the reason why: _____

Oxygen saturation of Right Hand: _____% Oxygen saturation of Foot: _____% which foot ☐ **Right** ☐ **Left**

(Oxygen saturation is determined by pulse oximetry)

If additional CCHD screenings were done to an initial retest or fail, please attach results of failed screenings to this form.

Hearing Screening -Call 860-509-8251 with Questions or visit https://portal.ct.gov/ehdi

Date: _____ Method: _____Right Ear Pass? ☐ **Yes** ☐ **No** Left Ear Pass? ☐ **Yes** ☐ **No**

Date: _____ Method: _____Right Ear Pass? ☐ **Yes** ☐ **No** Left Ear Pass? ☐ **Yes** ☐ **No**

☐ The parent refused (the refusal waver completed).
☐ Other reason(s) why the screening was not done (E.g. too ill) _____
What facility was the hearing screenings conducted at: _____
Was the newborn referred to an audiologist? ☐ **Yes** ☐ **No**
If Yes, please tell us who and the date of appointment. Name: _____Date: _____

CMV Screening

*If the child failed both hearing screenings, CMV testing is required **BEFORE** 21 Days of Birth.*

Date screened for CMV: _____ Result: ☐ **Not Detected** ☐ **Detected** (☐ ***Urine*** ☐ ***Saliva***)
☐ The parent refused (the refusal waver completed).
☐ Other reason(s) why the screening was not done (E.g. too ill) _____

Print Name and Title of Person Completing this form

Name: _____ Title: _____

Signature: _____ Date: _____ Phone: _____

Email: _____