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: Karin Davis, CFHPS Section at 860-509-7720 **(6/11/2018)**