



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) 920-6633 or submit with Blood Spot Specimen to State Laboratory

For CT NBS Program Staff Use Only: Date of Receipt _____ Accession #: _____

- ❖ 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.

Newborn 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 specimen collection take place between 24 and 48 hours of life (preferably as soon as possible after 24 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, 203-688-2446, 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) _____

Infant’s Gender: _____ Date of Birth: _____ Time of Birth (military time): _____ Birth weight: _____ (gms)

Birth Length: _____ (cm) Gestational age: _____ weeks, _____ days If multiple birth, indicate birth order: _____

Mother’s Name: (First) _____, (Last) _____ Mother’s DOB ___/___/___

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ (H) _____ (C) _____

Was the mother tested for HIV during pregnancy? Yes No

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

Phone: _____ Fax: _____ City/State: _____

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Infant's Name: _____ Date of Birth: _____

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

If yes, please specify _____ ICD10 code _____

1. 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: _____
2. Did the Mother have any male sexual partner(s) and **only** he traveled 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: _____
3. 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 1/15/18, results for CCHD are to be sent to CT DPH BDR

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 (Please call 860-509-8251 with questions or visit www.ct.gov/dph/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 waiver was completed).

Other reason(s) why the screenings weren't done (E.g. – too ill). _____

What facility was the hearing screening conducted at: _____

Was the newborn referred to an audiologist? Yes No

If so, please tell us who and the date of appointment: _____ Date: _____

Circle risk factors: Family History, NICU >5, Ototoxic meds, Syndromes, Genetic Anomalies, Other _____

CMV Screening (If the child failed their hearings screenings, CMV testing is required within 21 days of birth)

Date screened for CMV: _____ Result: Not Detected Detected

The parent refused (was documented internally).

Other reason(s) why the screening wasn't done (E.g. – too ill).

Please explain: _____

Printed name and title of person completing this form: _____

Signature of person completing this form: _____

Date: _____ Phone number: _____ Email: _____