Kansas Department of Health and Environment
Bureau of Family Health/Systems of Supports/Newborn Screening
Critical Congenital Heart Disease (CCHD) Diagnostic Echocardiogram Reporting Form
Instructions: Please complete the information below and fax to the Newborn Screening Program
Fax: 785-559-4240

Echocardiogram Result Report Form

Demographic Information			
Newborn's Name (Last, First	Date of Birth	Birthing Facility/Midwife	
Mother's Name (Last, First)			
Mother's Street Address	City	State	Zip Code

CCHD Screen Results					
Date of Screen	Time of Screen	Right Hand %	Foot %	Difference	Nursery Status

CCHD Not Screened due to

☐ CCHD diagnosed prenatally
☐ CCHD diagnosed clinically at birth
☐ CCHD ruled out by echocardiogram
☐ Transferred prior to screening
☐ Parents refused screening
☐ Expired
☐ Other _____

Echocardiogram Results		
☐ Diagnosis Excluded	Date Excluded __/__/____	Facility/Name of Specialist

☐ Baby does NOT have CCHD
☐ Baby had secondary condition (Sepsis, Pulmonary condition, etc.)
Please list_____
☐ Echo performed prior to screening and did not indicate CCHD
☐ Echo performed after positive CCHD screen and CCHD not found

☐ Diagnosis Confirmed	Date Confirmed __/__/____	Facility/Name of Specialist

Please check one

☐ Coarctation of the aorta
☐ Hypoplastic left heart syndrome
☐ Pulmonary atresia/stenosis
☐ Tetralogy of Fallot
☐ Other
☐ Transposition of the great arteries
☐ Tricuspid valve atresia/stenosis
☐ Truncus arteriosus
☐ Total anomalous pulmonary venous return