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Janet Stanek, Acting Secretary

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CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING REPORTING FORM

Please fax completed form to 785-559-4240

Patient Name: _____ **Date of Birth:** _____

Mother Name: _____ **PCP/Midwife Name:** _____

Screening Facility: _____

Date of CCHD Screen: _____

Final Screen Result

Right Hand % _____

Foot % _____

Difference % _____

Referred for Echocardiogram – Facility Name: _____

☐ **UNABLE TO COMPLETE SCREENING PROCESS:**

- ○ Infant Deceased
- ○ Parent refused Screening
- ○ Infant Discharged Before Screen
- ○ Prenatal Diagnosis - _____
- ○ Infant Transferred to NICU or Another Facility
- ○ Infant was on Oxygen
- ○ Echocardiogram Performed

Additional Notes: