

# Newborn Pulse Oximetry Screening For Critical Congenital Heart Disease Failed Screen Reporting Form

Date \_\_\_\_\_ Facility \_\_\_\_\_ MRN \_\_\_\_\_

Name (last, first)	DOB	Time of Birth (military)
Gestational age (weeks)	Birth Weight	Gender
Was a 2 <sup>nd</sup> trimester ultrasound performed? Yes      No      Don't Know		Infant's Primary Care Provider

Screening Information	First Pulse Ox Screen	Second Pulse Ox Screen (if indicated)	Third Pulse Ox Screen (if indicated)
Right hand	%	%	%
Foot	%	%	%
Age in hours	Hrs	Hrs	Hrs

Was an echocardiogram performed?      Y      N      Don't Know  
If yes- date \_\_\_\_\_ Facility \_\_\_\_\_

Echocardiogram reviewed by: \_\_\_\_\_

Was telemedicine used to review this echocardiogram?      Y      N      Don't know

Was the patient transferred?      Y      N  
If yes- Where? (Facility name) \_\_\_\_\_ Date of transfer \_\_\_\_\_

Findings (please list **all** diagnoses and include ICD10 codes):

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Comments: \_\_\_\_\_

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Person completing form: \_\_\_\_\_



**FAX COMPLETED FORM TO:**  
**Montana Newborn Screening Program**  
 Fax 406-444-2750  
 For questions call 406-444-3622

