TEXAS Health and Human Services | Texas Department of State Health Services

Clear Form

Critical Congenital Heart Disease Reporting Form

Chapter 37, Subchapter E. Newborn Screening for Critical Congenital Heart Disease of the Texas Administrative Code requires a physician, health care practitioner, health authority, birthing facility, or other individual who has information of a confirmed case of a disorder for which a screening test is required, to report the confirmed cases to the department.

Instructions

1. Complete form for all confirmed CCHD cases
2. Optional: Print form
3. Manually or digitally sign form
4. Fax signed form to **512-206-3909** Attention: CCHD Program, or email signed form to **CCHD@dshs.texas.gov**.

Demographics

Infant's First Name:

Infant's Last Name:

Infant's Date of Birth:

Infant's Race & Ethnicity, check all that apply:

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ Asian
- ☐ Native American
- ☐ Other

Infant's Age (in hours at time of screening):

Sex:

- ☐ Male
- ☐ Female
- ☐ Unknown

Birth Mother's First Name:

Birth Mother's Last Name:

Birth Mother's Maiden Name:

Birth Mother's Date of Birth:

Facility Name:

Facility Location (City):

Medical Record Number:

Facility Type:

- ☐ Children's Hospital
- ☐ Hospital
- ☐ Birthing Center
- ☐ Home Birth
- ☐ Other:

Diagnosis

Core Conditions (CCHD)

☐	Coarctation of the aorta	☐	Tetralogy of Fallot
☐	Double-outlet right ventricle	☐	Total anomalous pulmonary venous return
☐	Ebstein's anomaly	☐	D-transposition of the great arteries
☐	Hypoplastic left heart syndrome	☐	Tricuspid atresia
☐	Interrupted aortic arch	☐	Truncus arteriosus
☐	Pulmonary atresia	☐	Other critical cyanotic lesions not otherwise specified
☐	Single ventricle (not otherwise specified)	☐	

Comments:

Diagnosis Timeframe (choose only one):

- ☐ Prenatal diagnosis
- ☐ Postnatal diagnosis prior to pulse oximeter screening
- ☐ Postnatal diagnosis with pulse oximeter screening

If prenatally diagnosed, did prenatal and postnatal diagnosis match?

- ☐ Yes
- ☐ No

If no, what was the prenatal diagnosis?

Delivery outcome:

- ☐ Live birth
- ☐ Stillbirth

Infant status:

- ☐ Baby Living
- ☐ Baby Expired

Infant was transferred:

- ☐ Yes
- ☐ No

If yes, indicate for what purpose and check all that apply:

- ☐ Evaluation
- ☐ Treatment

Transferring facility:

Receiving facility:

Anticipated date of initial surgical repair:

If infant will not have surgical repair, please explain:

If infant has a comorbid syndrome or chromosomal abnormality, please specify here:

Signature

Print Name of person sending report:

Title:

Signature:

Date sent:

Fax signed form to 512-206-3909 Attention: CCHD Screening, or email signed form to CCHD@dshs.texas.gov

Email Form