



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

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:

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