NEWBORN SCREENING ONTARIO
DÉPISTAGE NÉONATAL ONTARIO

Children's Hospital of Eastern Ontario
401 Smyth, Ottawa Ont. K1H 8L1
(613)738-3222

Symptomatic Evaluation Report Form (SDRF) - CCHD

PATIENT INFORMATION

Infant's Name:		**Infant's OHIP:**	
DOB:	(yyyy/mm/dd)	**Infant's Sex:**	☐ Male ☐ Female ☐ Ambiguous
Mother's Name:			
Location of birth:	☐ Hospital ☐ Home ☐ Birth Centre ☐ Nursing Station ☐ Other		
Birth Facility/Submitter		**Episode number (NSO)**	

PULSE OXIMETRY

Was a CCHD Pulse Oximetry Screen completed?	☐ Yes ☐ No ☐ Unknown

CLINICAL INFORMATION

Date diagnosis made	(yyyy/mm/dd)	
Diagnosis:	☐ Hypoplastic Left Heart Syndrome ☐ Pulmonary Atresia with Intact Septum ☐ Transposition of the Great Arteries ☐ Truncus Arteriosus	☐ Tetralogy of Fallot ☐ Tricuspid Atresia ☐ Total Anomalous Pulmonary Venous Return ☐ Other, secondary (specify) _____ _____
How was the infant ascertained (check all that apply):	☐ Symptomatic, specify: ☐ Postmortem/Coroner ☐ Other, Specify: _____	
Age at symptom onset: (if applicable)		**Date of Death:** (if applicable)
Comments:		

☐ Parent/Guardian has consented to sharing this information with NSO.

FORM COMPLETED BY: _____ **Date:** _____
(*Name and Job Title*)

PHYSICIAN FOLLOWING INFANT FOR TARGET DISEASE: _____

Please fax completed form to **855-905-1493**
ATTN: CCHD Clinical Team at Newborn Screening Ontario