CCHD Diagnostic Evaluation Report Form

Last Name: **First Name:**

Health Card Number:		DOB:	
Episode Number:	NSO	Time of Birth:	
CCHD Form Number		Date of screen:	
Submitting Facility:		Time of screen(s):	
Screen performed by:		Age at first screen:	
Screen Positive for:	**CCHD**	Sex:	

Screen Results:

Initial Screen	SpO_2 R Hand	%
	SpO_2 Foot	%
First Repeat	SpO_2 R Hand	%
	SpO_2 Foot	%
Second Repeat	SpO_2 R Hand	%
	SpO_2 Foot	%

Was the infant symptomatic: ☐ Yes ☐ No ☐ Unknown

Was the baby referred based on (check all that apply): ☐ Screening results ☐ Clinical status

Referral within 6-8 hours? ☐ Yes ☐ No Assessment started within 6-8 hours? ☐ Yes ☐ No

✓ **Decision for care** *(check **all that apply** and complete relevant information)*:

	Infant brought to hospital	Date/Time of admission:	
	Care provided in hospital, no transfer	Date/time of decision:	
	Transfer within same hospital	Date/time of transfer:	
	Transfer to another hospital	Date/time of transfer:	

If transferred, specify transfer to:

Transported by (check one): ☐ Transport team ☐ Parents/Guardians ☐ Ambulance w/o transport team ☐ Other, specify:________________

Diagnostic Evaluation *(check **all that apply** and complete relevant information)*:

	Date/time of referral (YYYY/MM/DD HHMM)	**Date/time of assessment** (YYYY/MM/DD HHMM)	**Name of Practitioner**
Nurse practitioner			
Family doctor			
Emergency physician			
Paediatrician/Neonatologist			
Paediatric cardiologist			

Investigations *(check **all that apply** and complete relevant information)*:

✓	**Investigation**	**Date**	**Findings/Comments**
	4 limb BP		
	EKG		
	Chest XRAY		
	Physical Examination		
	Pre and Post Ductal Pulse Ox		

☐ **Echocardiogram** **Date:** **Findings:**

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✓ **Interventions** *(check **all that apply**)*:

- ☐ Oxygen
- ☐ Prostaglandin infusion
- ☐ Non-invasive positive pressure ventilation
- ☐ Intubation and ventilation
- ☐ IV antibiotics
- ☐ Monitoring
- ☐ None

✓ **Definitive Diagnosis** *(complete date and **check one**)*:

Date diagnosis made:

Primary targets		Incidental Findings: Secondary targets (Classic)		Incidental Findings: Secondary targets (Untargeted disease)	
☐	*Hypoplastic left heart syndrome*	☐	*Coarctation of the aorta*	☐	*Cardiac, Other (specify):* ☐ *structural defect* ☐ *arrhythmia* ☐ *other*
☐	*Pulmonary atresia w/ intact septum*	☐	*Double outlet right ventricle*		
☐	*Tetralogy of Fallot*	☐	*Ebstein anomaly*	☐	*Other, specify: (ventricular hypertrophy, PDA, thrombosis,)* ______________
☐	*Total anomalous pulmonary venous return*	☐	*Interrupted aortic arch*		
☐	*Truncus arteriosus*	☐	*Single ventricle*	☐	***No disease identified** Persistent low saturations, no definitive diagnosis*
☐	*Transposition of the great arteries*	☐	*Pulmonary disease, non infectious*	**Other**	
☐	*Tricuspid atresia*	☐	*Infection (eg sepsis, pneumonia)*	☐	***No disease identified** Normal exam, normal saturations*
		☐	*Persistent Fetal Circulation (includes pulmonary hypertension, delayed transition)*	☐	***Infant deceased prior to diagnosis** Date of death: ______________ Cause of death: ______________*
		☐	*PPHN*		

✓ **Plan for Care** *(complete date and check **one**)*:

Date of Plan of Care decision:

- ☐ Discharge
- ☐ Continue to follow with no treatment
- ☐ Treatment recommended or initiated
  - ☐ Surgical
  - ☐ Medicine
  - ☐ Other:

Comments:

FORM COMPLETED BY:		**Date:**	
Contact Number:			

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