CCHD Card Completion

Ensure all infant and submitter information is complete. Use of patient labels and submitter stamps is encouraged.

Complete the date and time of the screen

If the screen is **NOT** completed, indicate why here

Document CCHD results here, including saturation values and evaluation.

NEWBORN SCREENING **ONTARIO**
DÉPISTAGE NÉONATAL **ONTARIO**
415 Smyth Road, Ottawa, ON, K1H 8M8
Toll-free: 1-877-627-8330
newbornscreening@cheo.on.ca

* B 9 1 6 9 5 1 *

CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING RESULTS SHEET

INFANT

Last Name
First Name
Health Card Number
Submitter Unique Number
N/A A B C Multiple Birth
Sex: M F Ambiguous
LABEL
Y Y M M D D Date of Birth
H H M M AM PM Time of Birth

SUBMITTING HEALTH CARE PROVIDER

Hospital/Midwifery Practice Name
Address
City
Screen Performed By: Last Name
First Name

Initial screen *Evaluate screening result with NSO CCHD screening algorithm or evaluation chart*

Y Y M M D D Date of CCHD screen
H H M M AM PM Time of screen
R Hand: _____%
Foot: _____%
Difference: _____%
❑ Pass ❑ Repeat ❑ Refer *

First repeat *(if applicable)*

H H M M AM PM Time of screen
R Hand: _____%
Foot: _____%
Difference: _____%
❑ Pass ❑ Repeat ❑ Refer *

Second repeat *(if applicable)*

H H M M AM PM Time of screen
R Hand: _____%
Foot: _____%
Difference: _____%
❑ Pass ❑ Refer *

* **URGENT** physician assessment required **at time of screen**

Reason screen not done *(check box that applies)*

- ❑ Decline/deferred *(complete form on back of page)*
- ❑ Infant in or is expected to be in NICU/SCN/PICU over 7 days
- ❑ Infant diagnosed prenatally with heart defect
- ❑ Infant diagnosed with heart defect by physical exam
- ❑ Other (ex. limb anomaly). Specify: _____