NEWBORN SCREENING ONTARIO
DÉPISTAGE NÉONATAL ONTARIO

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

Symptomatic Diagnostic 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:		**Mother's OHIP:**	
Location of birth:	☐ Hospital ☐ Home ☐ Birth Centre ☐ Nursing Station ☐ Other		
Birth Facility: (if applicable)		**Episode number** (NSO)	

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
How was the infant ascertained (check all that apply):	☐ Symptomatic, specify: ☐ Post mortem/Coroner ☐ Other, Specify:	
Age at symptom onset: (if applicable)		**Date of Death:** (if applicable)
Comments:		

☐ **Release of Information form completed and signed by Parents/Guardians**

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

PHYSICIAN FOLLOWING INFANT FOR TARGET DISEASE: _____

Please fax completed SDRF along with your organization's Release of Information form to **613-738-0853**
ATTN: Robyn Kirkwood or Janet Marcadier at Newborn Screening Ontario
The SDRF is also posted on the Newborn Screening Ontario website at www.newbornscreening.on.ca