TEXAS Health and Human Services | Texas Department of State Health Services

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. Print form
3. Manually sign form
4. Fax signed form to **512-206-3909** Attention: CCHD Program

Facility Name:_____ Facility Location (City):_____

Medical Record #:_____ Mother Texas Resident: ☐ Yes ☐ No

Facility Type: ☐ Hospital ☐ Children's Hospital ☐ Birthing Center ☐ Home Birth ☐ Other

Infant's Name:
First_____ Last_____ 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: ☐ M ☐ F ☐ Unknown

Birth Mother's Name:

First_____ Last _____

Birth Mother's Maiden Name:_____ Birth Mother's Date of Birth:_____

Diagnosis

Core Conditions (CCHD)			
☐ 1	Coarctation of the aorta	☐ 9	Total anomalous pulmonary venous return
☐ 2	Double-outlet right ventricle		
☐ 3	Ebstein's anomoly	☐ 10	D-transposition of the great arteries
☐ 4	Hypoplastic left heart syndrome	☐ 11	Tricuspid atresia
☐ 5	Interrupted aortic arch	☐ 12	Truncus ateriosus
☐ 6	Pulmonary atresia	☐ 13	Other critical cyanotic lesions not otherwise specified
☐ 7	Single ventricle (not otherwise specified)		
☐ 8	Tetralogy of Fallot		

Comments: _____

_____

_____

_____

Diagnosis Timeframe (choose only one):

☐ Prenatal diagnosis

If prenatally diagnosed, did prenatal and postnatal diagnosis match? ☐Yes ☐No

If no what was the prenatal diagnosis? _____

☐ Postnatal diagnosis prior to pulse oximeter screening

☐ Postnatal diagnosis with pulse oximeter screening

Was postnatal echocardiogram performed? ☐ Yes ☐ No

Delivery Outcome: ☐ Live Birth ☐ Non-live birth

Current Treatment: ☐ Cardiac surgery ☐ Medical management ☐ Supportive care

Infant Status: ☐ Baby Living ☐ Baby Expired

Infant was transported: ☐ Yes ☐ No
If yes, indicate for what purpose and check all that apply:

☐ Evaluation

☐ Treatment

Infant has:

☐ Isolated heart disease

☐ Multiple anomalies

☐ Syndrome/chromosomal anomaly diagnosed

_____ _____
Printed name of person sending report Title

_____ _____
Signature of person sending report Date sent

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