Newborn Screening for Critical Congenital Heart Disease (Pulse Oximetry)
Failed Screen Reporting Form

Date:	Facility:	MRN:
Name (Last, First)	Date of Birth:	Time of Birth (Military)
Gestational Age (Weeks):	Birth Weight:	Gender:
Was a 2nd Trimester Ultrasound Performed? ☐ Yes ☐ No ☐ Unknown	Infant's Primary Care Provider:	

Screening Information	Pulse Ox #1	Pulse Ox #2
Right Hand	%	%
Foot	%	%
Age in Hours	Hrs	Hrs

Was an Echocardiogram Performed? ☐ Yes ☐ No ☐ Unknown

If yes, date: _____ Facility: _____

Echocardiogram Reviewed By: _____

Was Telemedicine used to review this Echocardiogram? ☐ Yes ☐ No ☐ Unknown

Was the patient transferred? ☐ Yes ☐ No

If yes, where? _____ Date of Transfer: _____

Findings (please include all diagnoses and include ICD10 codes):

Comments:

Person Completing Form: _____

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Fax Completed Form To:
Montana Newborn Screening Program
Fax: 406-444-2750
For Questions Call: 406-444-3657

MONTANA Newborn Screening