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

Baby's Name:
First_____ Last_____ Date of Birth:_____

Baby's Ethnicity:

☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

Baby's Age (in hours at time of screening):_____ Sex: ☐ M ☐ F ☐ Unknown

Mother's Name:
First_____ Last _____

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

Diagnosis

Primary Target Condition		Secondary Target Condition	
☐ 1	hypoplastic left heart syndrome	☐ 9	coarctation of the aorta
☐ 2	pulmonary atresia with intact septum	☐ 10	double outlet right ventricle
☐ 3	tetralogy of fallot	☐ 11	Ebstein anomaly
☐ 4	total anomalous pulmonary venous return	☐ 12	interrupted aortic arch
☐ 5	transposition of the great arteries	☐ 13	single ventricle
☐ 6	tricuspid atresia	☐ 14	unspecified secondary
☐ 7	truncus arteriosus		
☐ 8	unspecified primary		

Comments: _____

_____

_____

_____

Diagnosis Timeframe (choose only one):

☐ Prenatal diagnosis

If prenatally diagnosed, did prenatal and post-natal diagnosis match? ☐Yes ☐No

If no what was the prenatal diagnosis? _____

☐ Post-natal diagnosis prior to pulse oximeter screening

☐ Post-natal diagnosis with pulse oximeter screening

Was post-natal echocardiogram performed? ☐ Yes ☐ No

Delivery Outcome: ☐ Live Birth ☐ Non-live birth

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

Baby Status: ☐ Baby Living ☐ Baby Expired

Infant was transported: ☐ Yes ☐ No
If yes indicate for what purpose(s)

☐ 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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