DÉPISTAGE NÉONATAL ONTARIO | NEWBORN SCREENING ONTARIO

CCHD Diagnostic Evaluation Report Form

Name: ____

Health Card Number:		Submitting Facility/Midwifery Practice:	
Sex:	M ☐ F ☐ Ambiguous ☐		
Date of Birth:			
Date of Screen:		Screen Positive for:	**CCHD**

Screen Results:

Initial Screen	SpO_2 R Hand	%
	SpO_2 Foot	%
First Repeat	SpO_2 R Hand	%
	SpO_2 Foot	%
Second Repeat	SpO_2 R Hand	%
	SpO_2 Foot	%

Referral within 6-8 hours? Yes ☐ No ☐

Assessment within 6-8 hours? Yes ☐ No ☐

Was the infant symptomatic? Yes ☐ No ☐ Unknown ☐

Baby referred based on (check all that apply): Screening results ☐ Clinical status ☐

✓ **Decision for care** *(check **all that apply** and complete relevant information)*:

☐	Infant brought to hospital	Date/Time of admission:	
☐	Care provided in hospital, no transfer	Date/time of decision:	
☐	Transfer within same hospital	Date/time of transfer:	
☐	Transfer to another hospital	Date/time of transfer:	

If transferred, specify transfer to*:*

Transported by (check one): ☐ ACTS/Transport team ☐ Ambulance w/o transport team ☐ Parents/Guardians ☐ Other, specify:_________________

Diagnostic Evaluation *(check **all that apply** and complete relevant information)*:

	Date/time of referral (YYYY/MM/DD HHMM)	**Date/time of assessment** (YYYY/MM/DD HHMM)	**Name of Practitioner**
Nurse practitioner			
Family doctor			
Emergency physician			
Pediatrician/Neonatologist			
Pediatric cardiologist			

Investigations *(check **all that apply** and complete relevant information)*:

✓	**Investigation**	**Date**	**Findings/Comments**
☐	4 limb BP		
☐	EKG		
☐	Chest XRAY		
☐	Physical Examination		
☐	Pre and Post Ductal Pulse Ox		

☐	**Echocardiogram**	**Date:** _____________	**Findings:**	

Please complete both sides of this form, if double sided

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✓ **Interventions** *(check **all that apply**)*:

- ☐ Oxygen
- ☐ Prostaglandin infusion
- ☐ Non-invasive positive pressure ventilation
- ☐ Intubation and ventilation
- ☐ IV antibiotics
- ☐ Monitoring
- ☐ None

✓ **Definitive Diagnosis** *(complete date and **indicate most appropriate diagnosis**)*:

Date diagnosis made:

☐	*Hypoplastic left heart syndrome*	☐	*Coarctation of the aorta/Interrupted Aortic Arch/ Aortic Arch Hypoplasia*	☐	*Cardiac, Other (specify):* ☐ *structural defect* ☐ *arrhythmia* ☐ *other*
☐	*Pulmonary atresia w/ intact septum*	☐	*Double outlet right ventricle*		
☐	*Tetralogy of Fallot*	☐	*Ebstein anomaly/Tricuspid Valve Dysplasia/Severe Tricuspid Dysplasia*	☐	*Other, specify:* *(ventricular hypertrophy, PDA, thrombosis,)* _______________ _______________
☐	*Total anomalous pulmonary venous return*	☐	*Critical Pulmonary Valve Stenosis*		
		☐	*Critical Aortic Valve Stenosis*		
☐	*Truncus arteriosus*	☐	*Single ventricle*	☐	***No disease identified*** *Persistent low saturations, no definitive diagnosis*
☐	*Transposition of the great arteries*	☐	*Pulmonary disease, non-infectious*		**Other**
☐	*Tricuspid atresia*	☐	*Infection (e.g. sepsis, pneumonia)*	☐	***Not Affected*** *normal exam, normal saturations*
		☐	*Persistent Fetal Circulation (includes pulmonary hypertension (finding), delayed transition)*	☐	***Infant deceased prior to diagnosis*** *Date of death:* ______________ *Cause of death:* ______________
		☐	*PPHN (disease)*		

✓ **Plan for Care** *(complete date and check **one**)*:

Date of Plan of Care decision:

- ☐ Discharge
- ☐ Continue to follow with no treatment
- ☐ Treatment recommended or initiated
  - ☐ Surgical
  - ☐ Medicine
  - ☐ Other: ____________________

COMMENTS:

Form Completed By: **Date:**

Contact Number:

Please complete both sides of this form, if double sided

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