

Critical Congenital Heart Disease (CCHD)

North Dakota Administrative Code 33-06-01, North Dakota Century Code 23-07-01

**Report condition within seven days*

Newborn's last name _____

Newborn's first name _____

Newborn's date of birth (MM/DD/YYYY) _____

Newborn's medical record number _____

Newborn's sex at birth

- Male
- Female
- Ambiguous

Newborn's race (select all that apply)

- White/Caucasian
- American Indian/Alaskan Native
- Asian
- Black/African American
- Hawaiian/Pacific Islander
- Unknown

Location of newborn's birth

- In state - Hospital/birthing center
- In state - Home
- Out of state - Hospital/birthing center
- Out of state - Home
- Other, please specify _____

Display Logic

Select the hospital/birthing center used

- Altru Hospital-Grand Forks
- CHI St. Alexius-Bismarck
- CHI St. Alexius-Dickinson
- CHI St. Alexius-Devils Lake
- CHI St. Alexius-Williston
- Essentia Health-Fargo
- Jamestown Regional Medical Center-Jamestown
- McKenzie County Healthcare Systems-Watford City
- Quentin N Burdick-Belcourt
- Sanford Medical Center-Bismarck
- Sanford Medical Center-Fargo
- Trinity Hospital-Minot
- West River Regional Medical Center-Hettinger

Display Logic

Specify the out of state hospital/birthing center used

Mother's information:

Mother's last name _____

Mother's first name _____

Mother's street address _____

Mother's city _____

Mother's state _____

Mother's zip code _____

Mother's telephone number _____

Mother's email address _____

Was the newborn's CCHD diagnosed prenatally?

- Yes
- No
- Unknown

Display Logic

Did the newborn's mother have prenatal care?

- Yes
- No
- Unknown

Display Logic

Did the newborn's mother have a prenatal ultrasound?

- Yes
- No
- Unknown

Display Logic

Was the initial/first CCHD screen completed?

- Yes
- No
- Unknown

Display Logic

Date of first/initial CCHD screen (MM/DD/YYYY) _____

Time of first/initial screen (24-hour military time) _____

Age of newborn in hours (normal newborn nursery) or days (NICU) _____

SpO2 right hand (in %) _____

SpO2 foot (in %) _____

Display Logic

Initial/first newborn CCHD screening outcome

- Pass (screening complete)
- Repeat screen in 1 hour
- Fail (referred for immediate evaluation)

Display Logic

Initial/first newborn screen was not done due to: (select all that apply)

- CCHD diagnosed prenatally
- CCHD diagnosed clinically
- Transferred prior to screening
- Parents refused screening
- Newborn expired
- Other, please specify _____

Display Logic

Was the second CCHD screening completed?

- Yes
- No
- Unknown

Display Logic

Second CCHD screening results:

Date of second CCHD screen (MM/DD/YYYY) _____

Time of second screen (24-hour military time) _____

Age of newborn in hours (normal newborn nursery) or days (NICU) _____

SpO2 right hand (in %) _____

SpO2 foot (in %) _____

Display Logic

Newborn not screened a second time due to: (multiple choice)

- Low value on previous screen/referred for evaluation
- CCHD ruled out by echocardiogram
- Transferred prior to screening
- Parents refused further screening
- Newborn expired
- Other, please specify _____

Display Logic

Second CCHD screening outcome

- Pass (screening complete)
- Repeat screen in 1 hour
- Fail (referred for immediate evaluation)

Display Logic

Was a third CCHD screening completed?

- Yes
- No
- Unknown

Display Logic

Third CCHD screening results:

Date of third CCHD screen (MM/DD/YYYY) _____

Time of third screen (24-hour military time) _____

Age of newborn in hours (normal newborn nursery) or days (NICU) _____

SpO2 right hand (in %) _____

SpO2 foot (in %) _____

Display Logic

Newborn not screened a third time due to: (multiple choice)

- Low value on previous screen/referred for evaluation
- CCHD ruled out by echocardiogram
- Transferred prior to screening
- Parents refused further screening
- Newborn expired
- Other, please specify _____

Display Logic

Echocardiogram completed

- Yes
- No
- Unknown

Display Logic

Newborn was transferred to a referral hospital

- Yes
- No

Display Logic

Why was the newborn transferred? (Choose all that apply)

- Evaluation
- Treatment
- Other, please specify _____

Display Logic

Facility information that newborn was transferred to:

Facility Name _____

Facility City _____

Facility State _____

Final Disposition Section:

Which type of CCHD was this newborn diagnosed with? (Choose all that apply)

- AV canal (Q21.2)
- Critical Aortic Stenosis (Q23.0-Congenital Stenosis of aortic valve)
- Critical Pulmonary Stenosis (Q25.6-Artery (congenital), Q22.1-Valve (congenital))
- Coarctation of the aorta (Q25.1)
- Double Outlet Right Ventricle (Q20.1)
- Epstein Anomaly (Q22.5)
- Hypoplastic heart/univentricular heart (Q24.8)
- Interrupted Aortic Arch (Q25.21)
- Pulmonary Atresia (Q25.5-Artery, Q22.0-Valve)
- Tetralogy of Fallot (Q21.3)
- Total Anomalous Pulmonary Venous Return (Q26.2)
- Transposition of the Great Arteries (Q20.3)
- Tricuspid Atresia (Q22.4)
- Truncus Arteriosus (Q20.0)

Location of CCHD diagnosis

Facility Name _____

Facility City _____

Facility State _____

Diagnosing provider information

Provider first name _____

Provider last name _____

Provider credentials _____

Is this child still alive at the time of completing this form?

- Yes
- No
- Unknown

Display Logic

Date of death (MM/DD/YYYY)

Please provide any comments that you feel are pertinent to this newborn's case

Reporter information (person submitting this form)

Reporter first name _____

Reporter last name _____

Reporter credentials _____

Reporter email _____