PURPOSE – These instructions serve as a guide to birth providers reporting Congenital Heart Defect (CHD) screening and diagnosis efforts. All chief executive officers (CEOs), midwives or other legally responsible parties must assure that policies and procedures are developed for reporting CHD screening and diagnosis activities to the Pa. Department of Health (DOH) if these activities are occurring under their purview.

POLICY – The DOH encourages the screening of all newborns for CHD prior to discharge from a birthing facility. The attached forms shall constitute the information required to be reported to the Pa. DOH's Newborn Screening Program by the newborn screening coordinator in each facility. Newborn screening coordinators should be knowledgeable of newborn screening methodologies and serve as a point of contact between the facility and the DOH for all newborn screening activities occurring at a respective birth facility.

Instructions for PA DOH Congenital Heart Defect Reporting Form Attachment A:

FACILITY ID – Insert the hospital/birthing facility identification number.

HOSPITAL/BIRTHING FACILITY – Insert the hospital or facility name where birth occurred.

REPORT MONTH/YEAR: Insert the report month/year of the newborn's birth.

TABLE:

COLUMN #1 -Total Number of CHD Screens Performed – Populate column #1 by reporting each CHD screen performed.

COLUMN #2 - Total Number of positive CHD Screens Referred for Echocardiogram – See algorithm to determine what a positive screen is; if, as a result of following hospital protocol/algorithm, results are positive, populate column #1.

COLUMN #3 – Total Number of Echocardiograms Performed at Birth Hospital Due to Positive Pulse Oximetry Test – If infant has a positive Pulse Oximetry screen at birth hospital and the birth hospital performs echocardiograms, report that number in column #3.

COLUMN #4 – Total Number Transferred to Another Facility for Evaluation After Positive Pulse Oximetry - If infant has a positive Pulse Oximetry screen and needs to be evaluated at another facility, report the total number of infants transferred to another facility in column #4.

COLUMN #5 – Total Number of Infants Not Screened - Enter the total number of infants that are a) discharged/transferred prior to screening; b) the total number not screened due to parental refusal, or c) total number of infants not screened due to death (expired) in the corresponding columns.

Report Completed By – Name of individual completing the report.

Title – Title of the individual completing the report.

Date – Insert the date the form was completed in mm/dd/yyyy format.

Phone – Telephone number for the individual completing the report.

Notes – Additional comments regarding the report can be added.

Instructions for Pa. DOH Congenital Heart Defect Referred for Diagnosis Form ATTACHMENT B:

Note: Screening staff shall initiate Attachment B by completing all sections (including and up to "Mother's First Name") and send a copy to the Pa. DOH's Newborn Screening Program. The pediatric cardiologist should also receive a copy as part of the referral package, to complete and forward to the DOH upon final diagnosis.

Section A: To be completed by newborn screening coordinator at the hospital, birthing center or by midwife.

Name of Referring Hospital, Birthing Center or Midwife - Report the name of the transferring hospital, birthing center or midwife. Check the appropriate box for Hospital, Birthing Center, or Midwife.

Facility ID – Insert the facility identification number.

Name of Pediatric Cardiologist/Physician Referred To - Insert the name of the Pediatric Cardiologist to which you are referring the newborn for diagnosis.

Practice Tax ID – Insert the tax identification number for the practice.

Date and Time Referred – Insert the date using mm/dd/yyyy format and time of the referral.

Pediatric Cardiologist Phone Number - Insert the phone number of the Pediatric Cardiologist to which you are referring the newborn for diagnosis.

Filter Paper Number – Insert the filter paper number.

Date of Birth – Insert the date of the newborn's birth using mm/dd/yyyy format.

Newborn's Last Name – Insert the last name of the newborn being referred.

Newborn's First Name – Insert the first name of the newborn being referred.

Mother's Last Name – Insert the last name of the newborn's mother.

Mother's First Name – Insert the first name of the newborn's mother.

Section B: To be completed by the diagnosing medical professional or designee.

Date Referral Received – Insert the date the receiving hospital was notified or same as admission date in mm/dd/yyyy format.

Date of Initial Contact w/Patient – Insert the date the patient was seen by the Pediatric Cardiologist in mm/dd/yyyy format.

Diagnosis Date – Insert the date the Pediatric Cardiologist diagnosed the newborn in mm/dd/yyyy format.

Diagnosis Code – Insert the ICD 9/10 diagnosis code.

Congenital Anomalies of the Heart and Circulatory System - **745-746**

D01. Common Truncus	**745.0**
D02. Transposition of Great Vesseis	**745.10, 745.11, 745.12, 745.19**
D03. Tetralogy of Fallot	**745.2**
D04. Ventricular Septal Defect	**745.4**
D05. Atrial Septal Defect	**745.5**
D06. Endocardial Cushion Defecr	**745.60, 745.61, 745.69**
D07. Pulmonary Valve Atresia and Stenosis	**746.01 746.02**
D08. Tricuspid Valve Atresia and Stenosis	**746.1**
D09. Ebstein's Anomaly	**746.2**
D10. Aortic Valve Stenosis	**746.3**
D11. Hypoplastic Left Heart Syndrome	**746.7**
D12. Patent Ductuc Arteriosis	**747.0**
D13. Coarctation of Aorta	**747.10**
D14. Pulmonary Artery Anomalies	**747.3**

Treatment Recommendations – Check identified treatment recommendations.

Date Treatment Initiated – Insert the date treatment was initiated in mm/dd/yyyy format.

Prognosis **–** Check the newborn's prognosis.

Lack of Follow-Up – Check the appropriate box: No-show, Referred Elsewhere, Expired

Physician Signature - Signature should be made by the physician who made the diagnosis.

Date – Insert the date the form was completed in mm/dd/yyyy format.

Attachment A

pennsylvania
DEPARTMENT OF HEALTH

MONTHLY CONGENITAL HEART DEFECT REPORT
NEWBORN SCREENING POINT-OF-CARE PROGRAM

Facility ID:_____

HOSPITAL/BIRTHING FACILITY:_____Report Month/Year:_____

Reporting Month	#1 Total number of CHD screens performed	#2 Total number of positive CHD screens referred for echocardiogram	#3 Total number of echocardiograms performed at birth hospital due to positive PulseOx	#4 Total number transferred to another facility for evaluation after positive PulseOx	#5 Total number of infants not screened		
					a. Discharged/ Transferred Prior to Screen	b. Parental Refusal	c. Expired
Day 1-7							
Day 8-14							
Day 15-21							
Day 22-28							
Day 29-31							

Please remit this form by the **20th** of the following month to:

PA DEPARTMENT OF HEALTH
NEWBORN SCREENING POINT-OF-CARE PROGRAM
7TH FLOOR EAST WING, H and W BLDG
HARRISBURG, PA 17120
FAX: 717-213-3784 EMAIL TO: nsfp@pa.gov PHONE : 717-783-8143

Report completed by: _____Title: _____ Date: _____

Phone: _____

Notes: _____

_____

_____

_____

pennsylvania
DEPARTMENT OF HEALTH

Attachment B

Congenital Heart Defect

REFERRED FOR DIAGNOSIS

Section A: To be completed by Newborn Screening Coordinator at hospital, birthing center or by midwife					
Name of Referring Hospital, Birthing Center or Midwife:				☐Hospital ☐Birthing Center ☐Midwife	Facility ID:
Name of Pediatric Cardiologist/Physician Referred to:			Practice Tax ID:	Date and Time Referred:	Pediatric Cardiologist/Physican Phone Number:
Filter Paper Number:	Date of Birth: (mm/dd/yyyy)	Newborn's Last Name:	Newborn's First Name:	Mother's Last Name:	Mother's First Name:
Section B: To be completed by the diagnosing medical professional or designee.					
Date Referral Received:	Date Initial Contact with Patient:		Diagnosis Date:	Diagnosis Code:	
Treatment Recommendations ☐Surgery/Transplant ☐Medication/Therapy ☐Other	Date Treatment Initiated:		Prognosis ☐Poor ☐Fair ☐Good ☐Excellent		
Lack of Follow-up ☐No-show ☐Referred Elsewhere ☐Expired					

Return by fax to 717-213-3784.

Health care practitioners, including physicians and surgeons, and healthcare facilities, including birthing centers and hospitals, are required to report final diagnoses of certain diseases in the newborn child to the Pennsylvania Department of Health, Bureau of Family Health, Division of Newborn Screening and Genetics, (see 35 P.S. §521.16; 28 Pa. Code §27.1; 28 Pa. Code §27.30; 28 Pa. Code §27.21a; and effective July 1, 2009 35 P.S. §623).

Physician's Signature: _____ Date: _____

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