Critical Congenital Heart Disease Screening Program

SCREENING FORM

Place Label or Write-In Information

Medical Record # _______________________________________________________________

Patient Name: Last_________________________ First____________________________

Date of Birth _____ / _____ / ______

Age at Initial Screening: ______________________________ hours

Initial Screening:

Time _____________________________________________

Pulse Ox Saturation of Right Hand __________________ %

Pulse Ox Saturation of Foot __________________ %

Absolute difference ______________________ %

Pass □ Fail □ Retest

Second Screening: (1 hour following initial screen if fail initial screen)

Time _____________________________________________

Pulse Ox Saturation of Right Hand __________________ %

Pulse Ox Saturation of Foot __________________ %

Absolute difference ______________________ %

Pass □ Fail □ Retest

Third Screening: (1 hour following second screening if fail second screen)

Time _____________________________________________

Pulse Ox Saturation of Right Hand __________________ %

Pulse Ox Saturation of Foot __________________ %

Absolute difference ______________________ %

Pass □ Fail

○ If pulse ox saturation is 89% or less in either the hand or foot, the infant’s MD or NP must be notified immediately. “Fail must be checked”.

○ If pulse ox saturations are 94-90% in both the hand and foot or there is a 4% or more absolute difference between the two on three measures each separated by one hour the MD or NP must be notified.

○ If pulse ox saturations are 95-100% in either extremity, with a 3% or less absolute difference between the two, the reading is expected for an infant. “Pass” should be checked.

Screener’s Name: _______________________________________________________________

Screener’s Signature: __________________ Date: _____ / _____ / _____