Congenital Cytomegalovirus (cCMV) Laboratory Case Report Form

Instructions: As of October 10, 2024, all cCMV-positive laboratory results collected from infants <21 days of age must be reported to DPH within 7 days of the result. Submit this form to the Georgia Newborn Screening Program by faxing to (404) 657-2773 or email to DPH-NBS@dph.ga.gov

CHILD INFORMATION

Child's Name (Last)	(First)		**Date of Birth:** / / {MM/DD/YYYY}
Address	**City**	**State**	**ZIP**
Mother's Name (First and Last)	**Phone Number**		

Race: ☐ Asian/Polynesian ☐ Native Am/Alaskan ☐ Black ☐ White ☐ Multiracial ☐ Unknown	**Ethnicity:** ☐ Not Hispanic ☐ Hispanic ☐ Unknown	**Primary Language:** ☐ English ☐ Other _____	**Sex:** ☐ Male ☐ Female ☐ Other
Primary Care Physician (PCP) Name (First and Last)	**PCP Address** (Street, City, State, and ZIP)		**PCP Phone Number** **PCP Fax Number**
Multiple Birth? ☐ No ☐ Yes *If Yes, which order (e.g. 1,2,3):* _____	**Child's Birthing Facility:**	**Form/ Kit #** (if known) *Located on the NBS card*	**Is Child Currently Hospitalized?** ☐ Yes ☐ No ☐ Unknown

REPORTER INFORMATION

Reporter Name (First and Last)	**Reporting Facility**	**Reporter Phone Number**
Date of Report: / / {MM/DD/YYYY}		

TEST INFORMATION

Specimen Source ☐ Saliva ☐ Urine ☐ Other: _____	**Date of Specimen Collection** / / {MM/DD/YYYY}	**Specimen ID** (if known):
Test Type ☐ PCR ☐ LAMP ☐ Other: _____	**Laboratory Name**	**Test Result** ☐ Positive ☐ Negative ☐ Inconclusive. *If selected, indicate reason:*_____ ☐ Other: _____

Comments:

SendSS ID: _____ (Internal Use Only)