GEORGIA DEPARTMENT OF PUBLIC HEALTH

Newborn Screening (NBS) Delayed Screening Report Form

Instructions: Complete the form to report hearing and/or critical congenital heart disease (CCHD) screening result(s) that were not documented on the NBS dried bloodspot card. Reporting is mandated for hospitals and delivery facilities by **Georgia Department of Public Health Code Rules 511-5-5-.05** and **511-5-5-.06**. Forward the completed form to the Georgia Newborn Screening Program by faxing to (404) 657-2773 or email to DPH-NBS@dph.ga.gov.

Form/Kit Number (located on NBS card)
Child's Mother's Name (First and Last Name at Delivery)

Place Hospital Label Here

*If the child's hospital label is not available, please complete the Child's Information section. **Skip** the Child's Information if a hospital label is available.*

CHILD'S INFORMATION		
Child's Last Name	**Child's First Name**	**Child's Date of Birth** (MM/DD/YYYY)
Sex: ☐ Male ☐ Female	**Child's Medical Record #**	

SUBMITTER INFORMATION	
Submitting Facility Name	**Was the infant screened in NICU?** ☐ Yes ☐ No ☐ Not Applicable
Was the infant transferred to your facility from another facility? ☐ No ☐ Yes	**If the child was transferred to your facility, enter the transfer facility's name:**

HEARING SCREENING RESULTS			
Hearing Screening Date (MM/DD/YYYY)	**Left Ear Result:** ☐ Pass ☐ Fail	**Right Ear Result:** ☐ Pass ☐ Fail	**Hearing Screening Method:** ☐ aABR ☐ aOAE ☐ aABR and aOAE

CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING RESULTS			
Initial CCHD Screening Date (MM/DD/YYYY)	**Right Hand (%)** *Pulse Ox Saturation*	**Foot (%)** *Pulse Ox Saturation*	**Initial CCHD Result** *(right hand - right foot)* ☐ Pass ☐ Fail ☐ Rescreen
Repeat CCHD Screening Date *If rescreen is required, repeat only once, 1-hour after the initial screening.* (MM/DD/YYYY)	**Right Hand (%)** *Pulse Ox Saturation*	**Foot (%)** *Pulse Ox Saturation*	**Repeat CCHD Result** *(right hand - right foot)* ☐ Pass ☐ Fail ☐ Rescreen

ECHO RESULTS (IF APPLICABLE)		
Did the child have an ECHO? ☐ Yes ☐ No	**ECHO Date** (MM/DD/YYYY)	**ECHO Result:** ☐ Normal ECHO ☐ Abnormal ECHO

REFERRAL INFORMATION (IF FAILED CCHD):
Name of Physician or Hospital Referred to and Contact Information:

Date Reported to DPH:

Print