Massachusetts Department of Public Health
Screening for Critical Congenital Heart Disease (CCHD)
Data Reporting Form

Section 1. Hospital Information

Name of Hospital/Birthing Center _____

Person Completing the Survey

Name _____

Title _____

Contact Person (for any follow-up questions)

Name _____

Title _____

Telephone _____

E-mail _____

Section 2. Screening Information

Please specify the quarter for which you are reporting the screening information. For example, if you are submitting data collected from July 1, 2013 to September 30, 2013, please write, "July 1, 2013-September 30, 2013."

Reporting Period _____

Please provide the following aggregate data on newborns screened at your facility:

Total Number of Newborns Screened _____

Number of Positive Screening Results _____

Number of Negative Screening Results _____

Please provide aggregate data for any known cases of false positive or false negative results. The definitions of false positive and false negative results may be found in the CCHD Pulse Oximetry Screening and Reporting Factsheet.

Number of False Positive Results _____

Number of False Negative Results _____

Please send the completed forms to Cathy Higgins at Cathleen.Higgins@state.ma.us, or 617-624-5574 (fax).