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).

May 10, 2013