

CHAMPION REPORTING FORM UTAH BIRTH DEFECT NETWORK

Maternal Information

Name:	Date of Birth:
Delivery Hospital:	Hospital MRN #:

Infant Information

Name:	Date of Birth:
Primary Care Physician:	Gender: M F

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|------------------------------------|-----------------------------------|-------------------------------|
| 22q11 Deletion | Craniosynostosis | Limb Reduction Defect _____ |
| Abdominal Wall Defect | Critical Congenital Heart Disease | Microcephaly _____ cm |
| Amniotic Bands | CHD Other (specify) _____ | Head Circumference _____ in |
| Anencephaly | Cystic Kidneys | Neural Tube Defects |
| Anotia/Microtia | Encephalocele | Omphalocele |
| Anophthalmia/Microphthalmia | Esophageal Atresia / TE Fistula | Other CNS Malformations _____ |
| Arthrogyrosis | Dandy-Walker Malformation | Renal Agenesis/Dysgenesis |
| Biliary atresia | Diaphragmatic Hernia | Spina Bifida |
| Bladder Extrophy | Gastroschisis | Trisomy 13 |
| Choanal Atresia | Hirschsprungs | Trisomy 18 |
| Chromosomal Defect (specify) _____ | Holoprosencephaly | Trisomy 21 |
| Cleft Lip Only | Hypospadias/Epispadias | Turners Syndrome |
| Cleft Palate Only | Hydrocephalus | Multiple Congenital Anomalies |
| Cleft Lip and Palate | Imperforate Anus | Other Defect (specify) _____ |
| Congenital Cataract | Intestinal Atresia/Stenosis | |

CCHD Screening

	Date	Time	R Hand	Foot	Result		
1 st Attempt					P	F	Rescreen
2 nd Attempt					P	F	Rescreen
3 rd Attempt					P	F	

Not Screened Reason _____

ECHO Date _____ ECHO Time _____

Reporting Source:		Date:	
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