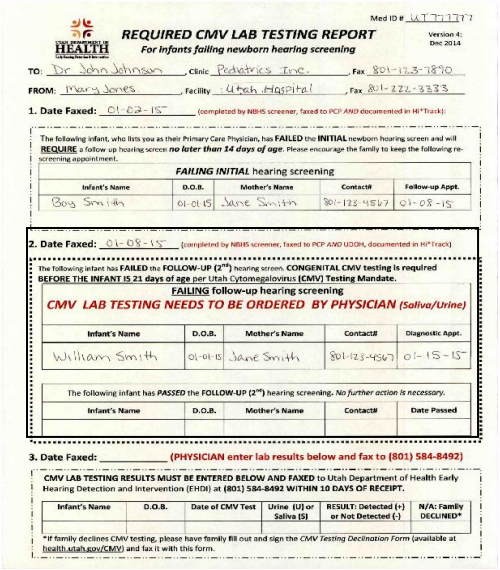
Hospital Births:

Referral and Testing For CONGENITAL Cytomegalovirus (CMV)

UTAH DEPARTMENT OF HEALTH
Early Hearing Detection & Intervention
(801) 584-8215

1. <u>Fax a CMV Testing Referral Form</u> to the Primary Care Provider reporting an infant in your care *needs CMV testing* because they either **failed two hearing screenings** (both the inpatient and the outpatient screen) OR ***failed their first hearing screening at age 14 days or older***

   Fax Referrals for CMV testing look like this:



REQUIRED CMV LAB TESTING REPORT
For infants failing newborn hearing screening

TO: Dr John Johnson, Clinic Pediatrics Inc. Fax 801-123-1890
FROM: Mary Jones, Facility Utah Hospital Fax 801-222-3333
1. Date Faxed: 01-02-15 (completed by NBHS screener, faxed to PCP AND documented in Hi*Track):

The following infant, who lists you as their Primary Care Physician, has FAILED the INITIAL newborn hearing screen and will REQUIRE a follow up hearing screen no later than 14 days of age. Please encourage the family to keep the following re-screening appointment.

FAILING INITIAL hearing screening

Infant's Name	D.O.B.	Mother's Name	Contact#	Follow-up Appt.
Boy Smith	01-01-15	Jane Smith	801-123-4567	01-08-15

2. Date Faxed: 01-08-15 (completed by NBHS screener, faxed to PCP AND UDOH, documented in Hi*Track)

The following infant has FAILED the FOLLOW-UP (2nd) hearing screen. CONGENITAL CMV testing is required BEFORE THE INFANT IS 21 days of age per Utah Cytomegalovirus (CMV) Testing Mandate.

FAILING follow-up hearing screening

CMV LAB TESTING NEEDS TO BE ORDERED BY PHYSICIAN (Saliva/Urine)

Infant's Name	D.O.B.	Mother's Name	Contact#	Diagnostic Appt.
William Smith	01-01-15	Jane Smith	801-123-4567	01-15-15

The following infant has PASSED the FOLLOW-UP (2nd) hearing screening. No further action is necessary.

Infant's Name	D.O.B.	Mother's Name	Contact#	Date Passed

3. Date Faxed: _____ (PHYSICIAN enter lab results below and fax to (801) 584-8492)

CMV LAB TESTING RESULTS MUST BE ENTERED BELOW AND FAXED to Utah Department of Health Early Hearing Detection and Intervention (EHDI) at (801) 584-8492 WITHIN 10 DAYS OF RECEIPT.

Infant's Name	D.O.B.	Date of CMV Test	Urine (U) or Saliva (S)	RESULT: Detected (+) or Not Detected (-)	N/A: Family DECLINED*

*If family declines CMV testing, please have family fill out and sign the CMV Testing Declination Form (available at health.utah.gov/CMV) and fax it with this form.

2. A sample will need to be collected **<u>BEFORE</u>** <u>the infant is **21 days** old:</u>

Urine		**Saliva***		Blood
	**OR**		NOT	
Acceptable		***Acceptable**		**UNacceptable**

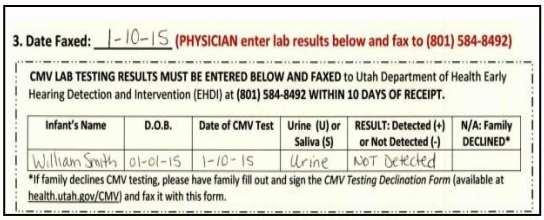
2 hours or more *after* feeding

*Must use ORAcollect-100 kit available from ARUP supply #49295

3. The sample will need to be sent to the lab for **<u>CMV PCR testing</u>** with **"CC: Utah Dept. of Health/CMV"**

   CPT code **<u>87496</u>** (Viracor-IBT is 87497) with ICD-9 code **389.8** (neonatal hearing loss)

4. When lab results are received, complete section 3 of Hearing Screening Form and **fax results to UDOH at (801) 584-8492**



3. Date Faxed: 1-10-15 (PHYSICIAN enter lab results below and fax to (801) 584-8492)

CMV LAB TESTING RESULTS MUST BE ENTERED BELOW AND FAXED to Utah Department of Health Early Hearing Detection and Intervention (EHDI) at (801) 584-8492 WITHIN 10 DAYS OF RECEIPT.

Infant's Name	D.O.B.	Date of CMV Test	Urine (U) or Saliva (S)	RESULT: Detected (+) or Not Detected (-)	N/A: Family DECLINED*
William Smith	01-01-15	1-10-15	Urine	NOT Detected	

*If family declines CMV testing, please have family fill out and sign the CMV Testing Declination Form (available at health.utah.gov/CMV) and fax it with this form.

5. Give the parent a *"Congenital CMV and Hearing Loss"* brochure and a copy of this form to facilitate lab testing

Find Out More
Health.utah.gov/CMV