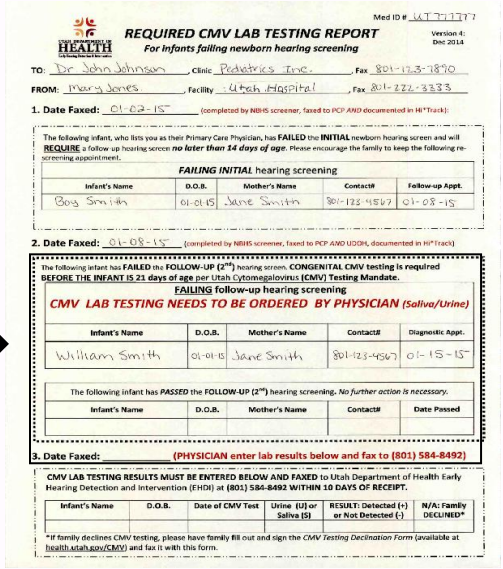
Collection and Testing For CONGENITAL Cytomegalovirus (CMV) for Medical Providers

CMV

1. Receive a referral from a Newborn Hearing Screening Program reporting an infant has *failed* hearing screening(s) and that *CMV testing is needed*

   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 801-123-7890
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.

   - If you receive a fax for an infant that is *not* your patient, please **call UDOH at (801) 584-8215.**

UTAH DEPARTMENT OF HEALTH

2. Collect a sample **BEFORE** the infant is **21 days** old.

Urine

Acceptable

OR

Saliva*

Acceptable

NOT

Blood

UNacceptable

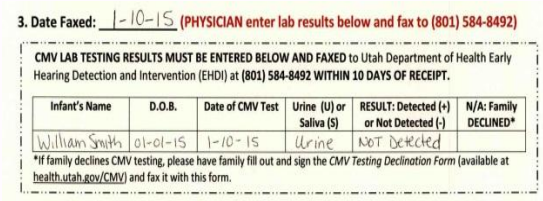
2 hours or more *after* feeding

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

3. Send the sample to the lab for **CMV PCR testing** with **"CC: Utah Dept. of Health CMV".**

4. Order CPT code **87496** (Viracor-IBT is 87497) with ICD-9 code 389.8 (neonatal hearing loss).

5. 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.

Find Out More

Health.utah.gov/CMV