

**CHAMPION REPORTING FORM
 UTAH BIRTH DEFECTS NETWORK**

Maternal Information

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

Infant Information

Name:	Date of Birth:
Primary Care Physician:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F

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

CCHD Screening

	Date	Time	R Hand	Foot	Result
1 st Attempt					<input type="checkbox"/> P <input type="checkbox"/> F <input type="checkbox"/> Rescreen
2 nd Attempt					<input type="checkbox"/> P <input type="checkbox"/> F <input type="checkbox"/> Rescreen
3 rd Attempt					<input type="checkbox"/> P <input type="checkbox"/> F

Not Screened Reason _____

ECHO Date _____ ECHO Time _____

Reporting Source:		Date:	
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