NBS Monthly Summary Report (MSR): Heel Stick & Pulse Oximetry Summary

Indiana Department of Health

All fields on this form must be completed prior to submission. Reach out to the NBS Reporting Coordinator at **NewbornScreening@health.in.gov** or at 317-233-7019 for assistance.

Facility Name:

Date this form was completed:

Name of staff member completing this form:

Phone number to reach above staff member:

Email address to reach above staff member:

Month and year of the MSR data within this report (ex. March 2022):

Total number of live births (born at this facility):

Heel Stick Summary:

Total number of home births that had a **HEEL STICK** at this facility:

Total number of walk-ins that had a **HEEL STICK** at this facility:

Total number of exceptions from the **HEEL STICK** at this facility:

Pulse Oximetry (CCHD Screen) Summary:

Total number of home births that had **PULSE OXIMETRY** at this facility:

Total number of walk-ins that had **PULSE OXIMETRY** at this facility:

Total number of exceptions from **PULSE OXIMETRY** at this facility:

Please email the completed form to **NewbornScreening@health.in.gov** or fax to 317-234-2995 **by the 15th of each month at 5pm EST.**

Last updated: 6/2023

NBS Monthly Summary Report (MSR): Exception Entry Form

Facility Name: **Month:**

Complete one exception form for EACH infant that was not screened. For example, if there are three infants not screened (3 exceptions), you will submit three Exception Entry Forms (one for each).

Please refer to the **MSR Quick Guide** for more information about how to report exceptions. Contact the NBS Reporting Coordinator at **317-233-7019** or **NewbornScreening@health.in.gov** for additional assistance.

Infant is an Exception for: **Pulse Oximetry** ☐ **Heel Stick** ☐

Exception Type(s): *(Check all that apply)*

Finally Screened

Religious Refusal (with waiver attached)

Discharged Home Without Screening

Transfer Out Without Screen

Transfer Date: Transfer Facility:

HEEL STICK ONLY:

Transfused

Deceased

PULSE OXIMETRY ONLY:

Prenatally Diagnosed with CCHD

Supplemental Oxygen/Respiratory Support

Deceased/Hospice Care

Echo Prior to Pulse Oximetry Screen *(enter echo details in the box directly below)*

If Infant is "Finally Screened" - Pulse Oximetry

1st Right Hand O2%:

1st Foot O2%:

If 1st screen did not pass:

2nd Right Hand O2%:

2nd Foot O2%:

Cardiac Echocardiogram Details:

Date Performed:

Echo: ***(normal/abnormal)***

Echo Not Performed/Unknown

If Infant is "Finally Screened" - Heel Stick

Date Heel Stick Performed:

Facility Performed:

Results: Normal Abnormal

Infant Information

DOB: MRN:

First Name: Last Name: Sex: TOB/ BO:

Mother Information

First Name: Last Name: MRN:

Address: Telephone:

Associated Providers

First Name: Last Name: Telephone:

Address:

Supplemental oxygen notes, echocardiogram details, heel stick results, pulse oximetry saturations and all other required information: