Indiana State Department of Health | Division of Maternal and Child Health

Newborn Screening Program

Pulse Oximetry Monthly Summary Report – Cover Sheet (Page 1 of 3)

Date of submission: _____

Month/year data: _____

Birthing facility name: _____

Address: _____

Name of person completing MSR: _____

Phone: _____ Fax: _____ E-mail: _____

☐ Check here if your facility's contact information has changed from previous months. This will help ISDH Newborn Screening Program keep e-mail and phone distribution lists current. Thank you!

Screening Statistics (report initial screens only)

Total number of live births this month: _____

Total number of home births that received screening: _____

Total number of walk-ins that received screening: _____

Number of exceptions reported to ISDH this month: _____

Number of screens*: _____

*Number of screens = (live births +home births + walk-ins) MINUS # exceptions reported to ISDH (**including "Finally Screened" & transfers**)

NOTE: Any infants who are discharged HOME without receiving a valid pulse oximetry screen must be reported immediately by phone to the ISDH Newborn Screening Program (317-233-9260).

Completed reports are due by 5 pm EST on the first business day after the 14th of the following month. Most of the time, MSRs will be due by 5 pm EST on the 15th—however, if the 15th falls on a weekend, MSRs will be due by 5 pm EST the following Monday. Please submit your MSR to:

Eileen White, RN, BSN

(317) 234 – 2995 (fax)

EWhite1@isdh.IN.gov (Secure/Certified e-mail ONLY)

Pulse Oximetry Exception Reporting Form (page 2 of 3)

Facility: Month:

For each child who did not receive or did not pass his/her pulse oximetry screen at your facility this month, please COMPLETE the form below. **Items marked with (*) an asterisk are REQUIRED. Your MSR will not be processed until all required information is complete.** **Continue on page 2.**

Transfer Details a. Not transferred b. Transferred out of your facility c. Transferred into your facility

Exception Details
1. Transfer only 2. Finally screened 3. NICU 4. Initial screen next month 5. Deceased 6. Religious refusal
7. Discharged HOME without pulse oximetry screen 8. Prenatally/postnatally diagnosed with CCHD
9. Did not pass pulse oximetry screen -- referred for additional follow-up

Infant					Transfer details		Exception Details
Infant #	MRN*	Last name* First name*	DOB* Time of birth*	Gender* Birth order*	Transfer code* Date of transfer* (if applicable)	Name of other facility involved in transfer OR name of referral facility* (if applicable)	Exception code* Date of transfer/pulse ox/ death/ Religious Waiver/discharge (REQUIRED for exception codes 1, 2, 5, 6, 7, 8, 9)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

NOTE: Please verify all pulse oximetry newborn screening results for children who are reported with the "Did not pass pulse oximetry screen" exception code (code 9). These infants should have received three pulse ox screens with readings < 95% in both the right hand & foot **OR** a difference > 3% between the right hand & foot **OR** any pulse oximetry reading < 90%.

 Facility: Month:

Infant #	Mother			Primary care provider	
	Last name*	Maiden name	Address*	Last name*	Phone*
	First name*	Phone*	City/State/Zip*	First name*	
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					