

Out-of-Hospital Births:

Referral and Testing For CONGENITAL Cytomegalovirus (CMV)



1. Fax a CMV Testing Referral Form to the Primary Care Provider reporting an infant in your care *needs CMV testing* because they either **failed two hearing screenings** (both the initial and the re-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 NDIS screener, faxed to PCP AND documented in H/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.

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 NDIS screener, faxed to PCP AND UDCH, documented in H/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*
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.

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

<p>Urine</p>  <p>Acceptable</p>	<p>OR</p>	<p>Saliva*</p>  <p>*Acceptable</p>
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2 hours or more after feeding

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

Blood

NOT  **UNacceptable**

3. The sample will need to be sent to the lab for **CMV PCR testing** with **“CC: Utah Dept. of Health/CMV”**
CPT code **87496** (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 CMV 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