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:___________________________ **Sex: M F**

- ☐ **Microcephaly, Head Circumference**______
- **Hydrocephalus**
- ☐ **Arthrogryposis**
- ☐ **Other CNS Malformations**
- ☐ **Hypospadias/Epispadias**
- ☐ **Dandy-Walker Malformation**
- ☐ **Craniosynostosis**
- ☐ **Holoprosencephaly**
- ☐ **Anophthalmia/Microphthalmia**
- ☐ **Congenital Cataract**
- ☐ **Limb Reduction Defect**
- ☐ **Choanal Atresia**
- ☐ **Oral Facial Cleft**
- ☐ **Gastrointestinal Defects:**
  - **TE Fistula**
  - **Esophageal atresia**
  - **Intestinal atresia/stenosis**
  - **Hirschsprungs**
  - **Biliary atresia**

- ☐ **Neural Tube Defects**
- ☐ **Renal agenesis/dysgenesis**
- ☐ **Cystic Kidneyp**
- ☐ **Bladder Extrophy**
- ☐ **Abdominal Wall Defect**
- ☐ **Anotia/Microtia**
- ☐ **Diaphragmatic Hernia**
- ☐ **Amniotic Bands**
- **ChromosomeDefect:**___________
- **Other/Code:** ___________
- ☐ **Cyanotic Congenital Heart Disease**
- ☐ **Other Congenital Heart Disease**
- ☐ **Failed CCHD Screening**

	Date _______________			
	Time	R hand	Foot	Initials
1st				
2nd				
3rd				
	CCHD Screen - Pass Y N			

Reporting Source: ________________________**Date:**_______________

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UTAH DEPARTMENT OF
HEALTH
Utah Birth Defect Network