UTAH DEPARTMENT OF HEALTH
Utah Birth Defect Network

CHAMPION REPORTING FORM
UTAH BIRTH DEFECTS NETWORK

P.O.Box 144693
Salt Lake City, Utah
84114-4693

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Reset Form

Maternal Information	
Name:	**Date of Birth:**
Delivery Hospital:	**Hospital MRN #:**
Infant Information	
Name:	**Date of Birth:**
Primary Care Physician:	**Gender:** ◯ **M** ◯ **F**

- ☐ 22911 Deletion
- ☐ Abdominal Wall Defect
- ☐ Amniotic Bands
- ☐ Anencephaly
- ☐ Anotia/Microtia
- ☐ Anophthalmia/Microphthalmia
- ☐ Arthrogryposis
- ☐ Biliary atresia
- ☐ Bladder Extrophy
- ☐ Choanal Atresia
- ☐ Chromosomal Defect (specify) _____
- ☐ Cleft Lip Only
- ☐ Cleft Palate Only
- ☐ Cleft Lip and Palate
- ☐ Congenital Cataract
- ☐ Craniosynostosis
- ☐ Critical Congenital Heart Disease
- ☐ CHD Other (specify) _____
- ☐ Cystic Kidneys
- ☐ Encephalocele
- ☐ Esophageal Atresia / TE Fistula
- ☐ Dandy-Walker Malformation
- ☐ Diaphragmatic Hernia
- ☐ Gastroschisis
- ☐ Hirschsprungs
- ☐ Holoprosencephaly
- ☐ Hypospadias/Epispadias
- ☐ Hydrocephalus
- ☐ Imperforate Anus
- ☐ Intestinal Atresia/Stenosis
- ☐ Limb Reduction Defect _____
- ☐ Microcephaly Head Circumference _____ ◯ cm ◯ in
- ☐ Neural Tube Defects
- ☐ Omphalocele
- ☐ Other CNS Malformations _____
- ☐ Renal Agenesis/Dysgenesis
- ☐ Spina Bifida
- ☐ Trisomy 13
- ☐ Trisomy 18
- ☐ Trisomy 21
- ☐ Turners Syndrome
- ☐ Multiple Congenital Anomalies
- ☐ Other Defect (specify) _____

CCHD Screening

	Date	Time	R Hand	Foot	Result
1st Attempt					◯ P ◯ F ◯ Rescreen
2nd Attempt					◯ P ◯ F ◯ Rescreen
3rd Attempt					◯ P ◯ F

Not Screened Reason _____

ECHO Date _____ ECHO Time _____

Reset Form

Reporting Source:		**Date:**	

Revised 06/2018