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

Toll Free: (866) 818-7096
Fax: (385) 465-6017

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

- ☐ 22q11 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
- ☐ Cloacal Exstrophy
- ☐ Congenital Cataract
- ☐ Craniosynostosis
- ☐ Critical Congenital Heart Disease
- ☐ CCHD / CHD Other (specify) _____
- ☐ Encephalocele
- ☐ Esophageal Atresia / TE Fistula
- ☐ Dandy-Walker Malformation
- ☐ Diaphragmatic Hernia
- ☐ Gastroschisis
- ☐ Holoprosencephaly
- ☐ Hypospadias/Epispadias
- ☐ Hydrocephalus
- ☐ Imperforate Anus / Anorectal Malformation
- ☐ Intestinal Atresia/Stenosis
- ☐ Limb Reduction Defect (specify) _____
- ☐ Microcephaly Head Circumference ____ ☐ cm ☐ in
- ☐ Neural Tube Defects
- ☐ NAS / NOWS
- ☐ Omphalocele
- ☐ Other CNS Malformations (specify) _____
- ☐ Renal Agenesis/Dysgenesis
- ☐ Posterior Urethral Valves
- ☐ 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 _____

Reporting Source:		**Date:**	

Revised 4/8/2020