FAILED SCREEN REPORTING FORM

PLACE LABEL OR WRITE-IN INFORMATION

Medical Record #_____

Patient Name: Last _____ First _____

Mother's Name: _____ Date of Birth _____ /_____ / _____

Hospital: _____ Medical Provider: _____

ALABAMA NEWBORN SCREENING PROGRAM

Fax failed screens to **334-206-3791**

Age at Initial Screening: _____ hours

Initial Screening:

Time _____

Pulse Ox Saturation of Right Hand _____

Pulse Ox Saturation of Foot _____

Difference (right hand – foot) _____ ❑ Fail

Second Screening *(1 hour following initial screen if fail initial screen)*

Time _____

Pulse Ox Saturation of Right Hand _____

Pulse Ox Saturation of Foot _____

Difference (right hand – foot) _____ ❑ Fail

Third Screening (1 hour following second screening if fail second screen)

Time _____

Pulse Ox Saturation of Right Hand _____

Pulse Ox Saturation of Foot _____

Difference (right hand – foot) _____ ❑ Fail

Other etiology identified: ❑ Pulmonary ❑ Infection ❑ Unknown ❑ Other: _____

Transferred: _____

Provider referred to: _____

Screener's First Initial/Last Name: _____ Date: _____/_____/_____