FAILED PULSE OX SCREEN REPORTING FORM

ALABAMA Newborn Screening PROGRAM

ALABAMA PUBLIC HEALTH

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 between right hand and 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 between right hand and foot	
	❑ **FAIL*** *DO NOT repeat and proceed with immediate assessment*

Immediate Fail = Pulse ox less than 90% in the right hand or foot

Fail = Pulse ox less than 95% in both the right hand and foot and a saturation difference of 4% or greater

*Fail may require transfer to a NICU with pediatric cardiology services

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

Transferred: _____

Provider referred to: _____

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