Maine Birth Defects Program

Confidential Medical Report

Please Print Clearly Using Blue or Black Ink

Today's Date: _____/_____/______

Child's Information

Name: ____________________ ______________________ ____
Last First MI

DOB: _____/_____/_____ **or** **EDD:** _____/_____/_____

Sex: ☐ Male ☐ Female ☐ Undesignated

Birth Status: ☐ Live ☐ Still

Autopsy: ☐ Yes ☐ No

Birth Facility: ________________________________ **MR#** ____________________________ **Date of Discharge/Transfer** _____/_____/_____

Transfer Facility: _____________________________ **MR#** ____________________________ **If Deceased: Date of Death:** _____/_____/______

Diagnosis

☐ Prenatal ☐ At Birth ☐ Other _________________ **Status:** ☐ Pending ☐ Confirmed

Diagnosis confirmed by: ☐ Ultrasound ☐ Cytogenics ☐ Physical Exam

Cardiovascular	☐ Spina Bifida	☐ Bladder Exstrophy
☐ Aortic Valve Stenosis	***Chromosomal***	☐ Epispadias
☐ Atrial Septal Defect	☐ Down Syndrome (Trisomy 21)	☐ Hypospadias
☐ Coarctation of Aorta	☐ Trisomy 13	☐ Obstructive Genitourinary Defect
☐ Common Trucus	☐ Trisomy 18	☐ Renal Agenisis
☐ Ebstein's Anomaly	***Ear***	☐ Renal Hypoplasia
☐ Endocardial Cushion Defect	☐ Anotia	***Musculoskeletal***
☐ Hypoplastic Left Heart Syndrome	☐ Microtia	☐ Congenital Hip Dislocation
☐ Patient Ductus Arteriosus	***Eye***	☐ Diaphragmatic Hernia
☐ Pulmonary Valve Atresia	☐ Aniridia	☐ Gastroschisis
☐ Pulmonary Valve Stenosis	☐ Anophthalmia	☐ Omphalocele
☐ Tetralogy of Fallot	☐ Congenital Cataract	☐ Reduction Deformity, Lower Limbs
☐ Transposition of Great Arteries	☐ Microphthalmia	☐ Reduction Deformity, Upper Limbs
☐ Tricuspid Valve Atresia	***Gastronintestinal***	***Orofacial***
☐ Tricuspid Valve Stenosis	☐ Biliary Atresia	☐ Choanal Atresia
☐ Ventricular Septal Defect	☐ Esophageal Atresia	☐ Cleft Lip
☐ Unknown / Suspected Cardiac	☐ Hirshsprung's Disease	☐ Cleft Lip with Cleft Palate
Central Nervous System	☐ Pyloric Stenosis	☐ Cleft Palate
☐ Anencephalus	☐ Rectal & Large Intestinal Atresia	***Other***
☐ Encephalocele	☐ Rectal & Large Intestinal Stenosis	☐ Amniotic Bands
☐ Hydrocephalus	☐ Tracheoesophageal Fistula	☐ Fetal Alcohol Syndrome
☐ Microcephalus	***Genitourinary***	☐ Other

Mother's Information

Name: _______________________ ____________________ _____ **DOB:** _____/_____/_____ **MR#** __________________________
Last First M.I.

Address: ____

____
City State Zip Code

Phone: ____

Adoptive/Foster Parent(s) Name: ______________________________________

Address: ____
Street City State Zip Code

Phone: ____

Rev: 11/09/2011

Please Turn Over to Complete

M.Roy

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Referrals Made

☐ Children with Special Health Needs Program **Date:** ______/_____/______ ☐ Other: __________________________ **Date:** _____/______/______

☐ Child Development Services **Date:** _____/_____/_______ ☐ Other: __________________________ Date: _____/______/______

☐ Genetic Counseling **Date:** _____/_____/_______ ☐ Other: __________________________ **Date:** _____/______/______

Provider Information

Primary Pediatric Provider: ____ **Phone:** ______________________________

Specialty Provider: ____ **Phone:** ______________________________

Reporting Source: ____ **Phone:** ______________________________

Complete form online at https://linkmc.ums.maine.edu/mebdreport/mebdreport.aspx

Mail or fax completed form to: Department of Health and Human Services
Maine Birth Defects Program
11 SHS, 7th Floor, 286 Water Street
Augusta, ME 04333-0011
Fax: (207) 287-5355

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