For Inpatients: AFFIX PATIENT LABEL **Or**
WRITE IN BOTH PATIENT NAME & MR NUMBER
PATIENT NAME: _____
MR #: _____

For Outpatients: WRITE IN BOTH PT NAME & DOB
PATIENT NAME: _____
DOB: _____

PULSE OXIMETRY SCREENING

Guidelines

• If pulse oximetry saturation is 89% or lower in right hand **or** foot, contact newborn's provider immediately and record as **FAIL**.

• If pulse oximetry saturation is 90-94% in right hand **and** foot, **or** 4% or more difference between the right hand and foot for all three screening attempts then record as ***FAIL*** and notify the provider.

• If pulse oximetry saturation is 95% or higher in right hand or foot with less than 4% difference between right hand and foot, record as a ***PASS.***

☐ **Patient Ineligible** (CCHD diagnosis or ECHO)

RN /CNA to complete

Screening # 1

Date: ____/____/____ Time: _____ Age in hours: _____

Pulse Oximetry Saturation of Right Hand: _____%

Pulse Oximetry Saturation of Foot: _____% · PASS · FAIL

Difference (Right Hand - Foot): _____%

Screener's Signature: _____ Date: _____/ _____/ _____ Time:_____

Printed Name: _____

Screening # 2 (1 hour following initial screen if the newborn fails initial screen):

Date: ____/____/____ Time: _____ Age in hours: _____

Pulse Oximetry Saturation of Right Hand: _____%

Pulse Oximetry Saturation of Foot: _____% · PASS · FAIL

Difference (Right Hand - Foot): _____ %

Screener's Signature: _____ Date: _____/ _____/ _____ Time:_____

Printed Name: _____

Screening # 3 (1 hour following second screen if the newborn fails second screen):

Date: ____/____/____ Time: _____ Age in hours: _____

Pulse Oximetry Saturation of Right Hand: _____%

Pulse Oximetry Saturation of Foot: _____% · PASS · FAIL

Difference (Right Hand-Foot): _____%

Screener's Signature: _____ Date: _____/ _____/ _____ Time:_____

Printed Name: _____

Final Interpretation: ☐ **PASS** ☐ **FAIL**

PASS Results: I told the parent(s)/guardians and gave them a written copy of the screening results.

FAIL Results: I called and faxed results to: _____

Decision of Primary Care Provider: ☐ **Transfer to NICU** · ☐ **Call Cardiology to evaluate as IP**

Signature: _____ Date: _____/ _____/ _____ Time:_____

Printed Name: _____