



ChiLDReNLink

Form 03C Anomalies BASIC

B: ANOMALIES

<p>B1</p>	<p>Cardiovascular System (check all that apply):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Anomalous superior vena cava (SVC) <input type="checkbox"/> Aortic arch anomalies, without severe left pulmonary hypoplasia <input type="checkbox"/> Aortic arch anomaly with severe left pulmonary hypoplasia <input type="checkbox"/> Aortic coarctation <input type="checkbox"/> Atrial Septal Defect (ASD) <input type="checkbox"/> Artrioventricular Septal Defect (AVSD) <input type="checkbox"/> Complete atrioventricular (AV) canal <input type="checkbox"/> Dextrocardia <input type="checkbox"/> Double outlet left ventricle (LV) <input type="checkbox"/> Ebstein malformation <input type="checkbox"/> Interrupted inferior vena cava (IVC) <input type="checkbox"/> Left ventricle (LV) outflow obstruction <input type="checkbox"/> Patent ductus arteriosus <input type="checkbox"/> Peripheral Pulmonary Stenosis (PPS) <input type="checkbox"/> Pulmonary atresia <input type="checkbox"/> Single ventricle <input type="checkbox"/> Total/Partially anomalous pulmonary venous return (TAPVR/PAPVR) <input type="checkbox"/> Transposition of the great arteries (TGA) <input type="checkbox"/> Ventricular Septal Defect (VSD) not requiring intervention first 6 months <input type="checkbox"/> Ventricular Septal Defect (VSD) requiring intervention first 6 months <input type="checkbox"/> Other (specify): _____ <ul style="list-style-type: none"> <input type="checkbox"/> Absent inferior vena cava (IVC) <input type="checkbox"/> Atrial isomerism <input type="checkbox"/> Atrioventricular (AV) discordance <input type="checkbox"/> Bilateral superior vena cava (SVC) <input type="checkbox"/> Conduction system abnormalities <input type="checkbox"/> Double inlet left ventricle (LV) <input type="checkbox"/> Double outlet right ventricle (RV) <input type="checkbox"/> Hypoplastic left heart syndrome <input type="checkbox"/> Left atrial isomerism <input type="checkbox"/> Mesocardia <input type="checkbox"/> Patent foramen ovale <input type="checkbox"/> Pulmonary artery stenosis <input type="checkbox"/> Pulmonary valvular stenosis <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Unknown septal defect
<p>B2</p>	<p>Pulmonary System (check all that apply):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Diaphragmatic hernia <input type="checkbox"/> Impaired Mucociliary Clearance <input type="checkbox"/> Other (specify): _____ <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal lobation of lungs <input type="checkbox"/> Hyparterial/eparterial bronchi
<p>B3</p>	<p>Gastrointestinal System (check all that apply):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> None <input type="checkbox"/> Abnormal pancreatic structure <input type="checkbox"/> Absent portal vein <input type="checkbox"/> Anomalous hepatic artery <input type="checkbox"/> Duodenal/Jejunal atresia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Intestinal malrotation <input type="checkbox"/> Midline liver <input type="checkbox"/> Pancreatic cyst <input type="checkbox"/> Right-sided stomach <input type="checkbox"/> Transverse (left-sided) liver <input type="checkbox"/> Other (specify): _____ <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal heterotaxia <input type="checkbox"/> Absent hepatic artery <input type="checkbox"/> Annular pancreas <input type="checkbox"/> Anomalous portal vein <input type="checkbox"/> Esophageal atresia <input type="checkbox"/> Imperforated anus <input type="checkbox"/> Micrognathia/Agnathia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Preduodenal portal vein <input type="checkbox"/> Tracheoesophageal Fistula (TEF)

B: ANOMALIES

B4	Genitourinary System (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Bladder exstrophy <input type="checkbox"/> Cystic kidney <input type="checkbox"/> Fused adrenal glands <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Hypospadias 2nd or 3rd degree <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Sacral dysplasia <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Bifid/separate uterus and vagina <input type="checkbox"/> Cloacal exstrophy <input type="checkbox"/> Double ureter <input type="checkbox"/> Horseshoe kidney <input type="checkbox"/> Hydroureter <input type="checkbox"/> Micropenis <input type="checkbox"/> Renal dysplasia <input type="checkbox"/> Solitary kidney
B5	Musculoskeletal System (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Craniosynostosis <input type="checkbox"/> Limb deficiency, longitudinal <input type="checkbox"/> Persistent Fetal Pads <input type="checkbox"/> Vertebral and rib anomalies <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Clinodactyly <input type="checkbox"/> Limb deficiency, intercalary <input type="checkbox"/> Limb deficiency, transverse <input type="checkbox"/> Polydactyly
B6	Immune System (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Asplenia <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Polysplenia <input type="checkbox"/> Right-sided spleen
B7	Central Nervous System (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Dandy-Walker malformation <input type="checkbox"/> Encephalocele, meningocele, encephalomyelocele <input type="checkbox"/> Holoprosencephaly <input type="checkbox"/> Microcephaly <input type="checkbox"/> Occipital encephalocele <input type="checkbox"/> Sacral agenesis <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Cerebellar hypoplasia <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Neural tube defects <input type="checkbox"/> Prosencephaly
B8	Ear, Nose, and Throat (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Cleft lip/Cleft palate <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Choanal atresia
B9	Eye (check all that apply):	<input type="checkbox"/> None <input type="checkbox"/> Microphthalmia <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Anophthalmia
B10	Syndromes (check all that apply):	<input type="checkbox"/> None	<input type="checkbox"/> Chromosomal anomaly <input type="checkbox"/> Kartagener syndrome

C: INVESTIGATOR SIGNATURE

C1	Investigator Signed?	<input type="radio"/> No → Done	<input type="radio"/> Yes
C2	Date investigator signed	_____ / _____ / _____	