NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208
Phone: (518)473-7552 Fax: (518)474-0405
E-mail: nbsinfo@health.ny.gov

INHERITED METABOLIC DISORDER – UREA CYCLE – DIAGNOSIS FORM

Dear Doctor:
Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible.
Attach Clinical Laboratory results including any available mutation analysis.
Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.5e.

NEWBORN INFORMATION:

Name at Time of Birth: _____

Other Names (AKA): _____

Single Birth ☐ Twin A ☐ Twin B ☐ Other _____

Mother's Name: _____

Date of Birth: _____

Gender: Male ☐ Female ☐

Hospital of Birth: _____

Medical Record #: _____

Argininemia

ARG 01 [ ] Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
ARG 10 [ ] Disease Argininemia (ARG)
ARG 29 [ ] Disease, not on NBS panel: Specify: _____
ARG 30 [ ] Inconclusive, ARGININEMIA
ARG 40 [ ] No disease
ARG 41 [ ] No disease, transient elevation due to prematurity/TPN
ARG 71 [ ] Other, maternal disease or medication

ASA/Citrullinemia

CIT 01 [ ] Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
CIT 10 [ ] Disease, Citrullinemia 1
CIT 11 [ ] Disease, Citrullinemia 2 (citrin deficiency)
CIT 29 [ ] Disease, not on NBS panel: Specify: _____
CIT 30 [ ] Inconclusive, ASA/CITRULLINEMIA
CIT 40 [ ] No disease
CIT 41 [ ] No disease, transient abnormality due to prematurity/TPN
CIT 49 [ ] No disease, polymorphisms only
CIT 71 [ ] Other, maternal disease or medication

COMMENTS_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____