NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
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HEMOGLOBINOPATHY DIAGNOSIS FORM

Dear Doctor:
Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible. Please submit a repeat newborn screening specimen or send a copy of your independent laboratory results. Confirmatory testing is required, as specified in Title 10 NY 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 #: ___________________________________________________________

CHOOSE ONE DIAGNOSIS:

Hemoglobinopathies
HGB01 ☐ Expired. If cause of death is known, choose the appropriate diagnosis below
HGB10 ☐ Disease, Hemoglobin S + S (sickle cell disease)
HGB11 ☐ Disease, Hemoglobin S + C disease
HGB12 ☐ Disease, Hemoglobin S + D disease
HGB13 ☐ Disease, Hemoglobin S + E disease
HGB14 ☐ Disease, Hemoglobin S + beta thalassemia disease
HGB15 ☐ Disease, Hemoglobin S + other variant disease
HGB16 ☐ Disease, Hemoglobin C + C disease
HGB17 ☐ Disease, Hemoglobin C + D disease
HGB18 ☐ Disease, Hemoglobin C + E disease
HGB19 ☐ Disease, Hemoglobin C + beta thalassemia disease
HGB20 ☐ Disease, Hemoglobin C + other variant disease
HGB21 ☐ Disease, Hemoglobin D + D disease
HGB22 ☐ Disease, Hemoglobin D + E disease
HGB23 ☐ Disease, Hemoglobin D + beta thalassemia disease
HGB24 ☐ Disease, Hemoglobin E + E disease
HGB25 ☐ Disease, Hemoglobin E + beta thalassemia/other variant disease
HGB26 ☐ Disease, Hemoglobin H + alpha thalassemia disease
HGB27 ☐ Disease, Other hemoglobinopathy
HGB28 ☐ Disease, Hemoglobin F only + beta thalassemia disease

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HGB29  [ ] Disease, not on NBS panel. Specify: ________________________________
HGB30  [ ] Inconclusive, Hemoglobinopathy
HGB40  [ ] No disease
HGB41  [ ] No disease, Hemoglobin S trait (sickle trait)
HGB42  [ ] No disease, Hemoglobin C trait
HGB43  [ ] No disease, Hemoglobin D trait
HGB46  [ ] No disease, Hemoglobin E trait
HGB47  [ ] No disease, Hemoglobin other variant trait
HGB48  [ ] No disease, Alpha thalassemia trait

Hematology follow-up?   [ ] No
[ ] Yes, Name of Hematologist: ________________________________

                   Phone Number: ________________________________

                   Date of next appointment: ________________________________

What confirmatory testing was done?   [ ] Electrophoresis
[ ] HPLC
[ ] Mutation Analysis (Genotype)___________/__________________

                        Allele #1     Allele #2

[ ] Repeat newborn screen
[ ] Other, Specify:______________________________________________

COMMENTS: ___________________________________________________

_________________________________________________________________

PHYSICIAN’S SIGNATURE: ___________________________ DATE: __________

PRINT NAME: ___________________________FACILITY/PRACTICE: _____________