INHERITED METABOLIC DISORDER 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 #: ___________________________________

Galactosemia
GALT01 [ ] Expired. If cause of death is known, choose the appropriate diagnosis below.
GALT10 [ ] Disease, Galactosemia – classical
GALT11 [ ] Disease, Galactosemia – variant
GALT29 [ ] Disease, not on NBS panel. Specify: ____________________________
GALT30 [ ] Inconclusive, Galactosemia
GALT40 [ ] No disease
GALT41 [ ] No disease, transient abnormality due to prematurity/TPN
GALT49 [ ] No disease, polymorphisms only
GALT71 [ ] Other, maternal disease or medication

Biotinidase
BIOT01 [ ] Expired. If cause of death is known, choose the appropriate diagnosis below.
BIOT10 [ ] Disease Biotinidase – classical
BIOT11 [ ] Disease – partial Biotinidase deficiency
BIOT29 [ ] Disease, not on NBS panel. Specify: ____________________________
BIOT30 [ ] Inconclusive, Biotinidase
BIOT40 [ ] No disease
BIOT41 [ ] No disease, transient abnormality due to prematurity/TPN
BIOT71 [ ] Other, maternal disease or medication

COMMENTS: ____________________________________________

PHYSICIAN'S SIGNATURE: ____________________________ DATE: _______________

PRINT NAME: ______________________________________