NEWBORN SCREENING PROGRAM
New York State Department of Health
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CONGENITAL ADRENAL HYPERPLASIA DIAGNOSIS FORM

Dear Doctor:
Please complete this form in its **entirety** and return it to the Newborn Screening Program as soon as possible. Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.7c.

Note: Screening results do not constitute a diagnosis. Confirmatory testing is required.

NEWBORN INFORMATION

Name at birth: _____
AKA: _____

Single Birth ☐ Twin A ☐ Twin B ☐ Other _____
Mother's name: _____
Date of Birth: _____

Gender: Male ☐ Female ☐
Hospital of birth: _____
Medical Record #: _____

1. ATTACH CLINICAL LABORATORY RESULTS

Date of Test	Test	Result	Normal Range (required)
	17-OHP		

Was mutation analysis performed? [ ]No [ ]Yes Mutations detected: _____

2. Was this newborn previously known to be at increased risk for this disorder?
[ ] No [ ] Yes, family history [ ] Yes, prenatal testing [ ] Yes, preconception testing

3. CHOOSE ONE DIAGNOSIS

CAH01 **[ ]** Expired, If cause of death is known, choose the appropriate diagnosis below
CAH10 **[ ]** Disease, Congenital adrenal hyperplasia – 21-hydroxylase deficiency (classic, salt wasting)
CAH11 **[ ]** Disease, Congenital adrenal hyperplasia – 21-hydroxylase deficiency (classic, simple virilizing)
CAH12 **[ ]** Disease, Congenital adrenal hyperplasia – 21-hydroxylase deficiency (nonclassic)
CAH13 **[ ]** Disease, Congenital adrenal hyperplasia – other enzyme deficiency
CAH29 **[ ]** Disease, not on NBS panel – Specify: _____
CAH30 **[ ]** Possible disease, CAH – diagnostic work-up still in progress; please provide date of next visit/labs in comments below
CAH40 **[ ]** No disease
CAH41 **[ ]** No disease, transient elevation due to prematurity/TPN
CAH45 **[ ]** No disease, Carrier
CAH71 **[ ]** Other, maternal disease or medication

COMMENTS: _____

PHYSICIAN'S SIGNATURE: _____DATE:_____

PRINT NAME: _____FACILITY/PRACTICE: _____