

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

DUCHENNE MUSCULAR DYSTROPHY DIAGNOSIS FORM

Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible. **Screening results do not constitute a diagnosis. Confirmatory testing is required.** Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.7c.

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 #: _____

CK-MM level at birth: _____ Date: _____
 Repeat CK-MM if done (include date(s)): _____

Independent confirmatory sequencing panel date: _____

| Gene | Disease | Variant(s) | Interpretation |
|------|---------|------------|----------------|
| | | | |
| | | | |
| | | | |

Initial consult date by Neuromuscular specialist: _____

DIAGNOSIS

- | | |
|---|---|
| <input type="checkbox"/> Expired, diagnosis unknown <input type="checkbox"/> Normalized CK/no evidence of weakness <input type="checkbox"/> Duchenne Muscular Dystrophy <input type="checkbox"/> Becker Muscular Dystrophy <input type="checkbox"/> Dystrophin Carrier <input type="checkbox"/> Elevated CK-MM of unknown etiology | <input type="checkbox"/> Emery Dreifuss Muscular Dystrophy <input type="checkbox"/> Limb Girdle Muscular Dystrophy <input type="checkbox"/> Facioscapulohumeral Muscular Dystrophy <input type="checkbox"/> Congenital Myopathy <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Other muscular dystrophy: _____ |
|---|---|

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

Comments: _____

Physician signature: _____ Date: _____

Print name: _____ Facility/Practice: _____