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

[ ] Expired, diagnosis unknown
[ ] Normalized CK/no evidence of weakness
[ ] Duchenne Muscular Dystrophy
[ ] Becker Muscular Dystrophy
[ ] Dystrophin Carrier
[ ] Elevated CK-MM of unknown etiology
[ ] Emery Dreifuss Muscular Dystrophy
[ ] Limb Girdle Muscular Dystrophy
[ ] Facioscapulohumeral Muscular Dystrophy
[ ] Congenital Myopathy
[ ] Cardiomyopathy
[ ] 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: _____