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:______________________

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<th>Gene</th>
<th>Disease</th>
<th>Variant(s)</th>
<th>Interpretation</th>
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Initial consult date by Neuromuscular specialist: _____________

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