NEWBORN SCREENING PROGRAM
New York State Department of Health
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SEVERE COMBINED IMMUNODEFICIENCY DIAGNOSIS FORM

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: Newborn 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 #: ________________________________

PLEASE INDICATE A DIAGNOSIS:

- ❑ Expired. If cause of death is known, choose the appropriate diagnosis below.
- ❑ No evidence of immune dysfunction
- ❑ Severe combined immunodeficiency (Abs. T cells < 300), specify gene and mutation(s) if available: ___________________
- ❑ Leaky SCID/Omenn syndrome, (300 < Abs. T cells < 1500, abnormal mitogen studies) specify gene and mutation(s) if available: ____________________
- ❑ Variant SCID (300 < Abs. T cells < 1500, normal mitogens/mitogens not completed)
- ❑ Syndrome with T cell impairment, specify below:
  - ❑ DiGeorge Syndrome
  - ❑ CHARGE Syndrome
  - ❑ Down Syndrome
  - ❑ Other: please specify____
- ❑ Idiopathic T cell lymphopenia
  - Will additional testing be done to see if issue resolves? ☐Yes ☐No
  - Expected date of additional testing:______________________
- ❑ Secondary T cell lymphopenia
  - ❑ Heart defect/surgery
  - ❑ Gastroschisis
  - ❑ Thymectomy
  - ❑ Other, please specify:____
- ❑ Other, please specify: ____________________________________

**** Please attach confirmatory testing ****

Were mitogens done? □Yes □No **DATE**: ____________
□ Normal □ Abnormal

Was the patient referred for transplant evaluation? □Yes □No
Where were they referred? ___________________________

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

Comments:
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Physician signature: ____________________________Date: ___________________

Print Name______________________________ Facility/practice: ___________________