NEWBORN SCREENING PROGRAM
New York State Department of Health
David Axelrod Institute, 120 New Scotland Ave.
Albany, NY 12208
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E-mail: nbsinfo@health.ny.gov
Website: http://www.wadsworth.org/newborn/

CLICK TO RESET FORM

HEMOGLOBINOPATHY DIAGNOSIS FORM

Dear Provider:
Please complete Part I of this form and return it to the Newborn Screening Program (NBSP) as soon as possible. Please submit a repeat newborn screening specimen or send a copy of your independent laboratory results. Confirmatory testing is required, as specified in Title 10 NY Code of Rules and Regulations subpart 69-1.7c. Please complete and return Part II of this form when a diagnosis is confirmed.

Name at birth: _____ AKA: _____

Date of birth: _____ **Single Birth ○ Twin A ○ Twin B ○ Other _____**

Mother's name: _____

Hospital of birth: _____ Medical Record #: _____

Lab ID/Accession #: _____

Part I. (To be completed and returned as soon as possible)

1. What confirmatory testing was done and/or is planned by your office? Please send results when available.

Date of draw: _____

- ☐ Hemoglobin Electrophoresis
- ☐ HPLC
- ☐ CBC
- ☐ Genetic Testing (Gene Sequencing/Mutation Analysis)

- ☐ Repeat Newborn Screen
- ☐ Other, Specify: _____

2. Does this baby have an appointment at a Specialty Care Center (SCC)?

☐ Yes, center name and phone number: _____

Date of initial appointment: _____

☐ No specialist appointment. Why? Provide detailed comments on attempts to reach family and any issues the office or family is encountering:

_____

_____

3. Was this baby previously known to be at increased risk for this disorder?

☐ No ☐ Yes, family history ☐ Yes, prenatal testing ☐ Yes, preconception testing

COMMENTS: _____

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME and TITLE: _____ FACILITY/PRACTICE: _____

Name at birth: _____ AKA: _____ Date of birth: _____

Mother's name: _____ Lab ID/Accession #: _____

Part II. (To be completed and returned by specialist when a diagnosis is confirmed)

Diagnosis Date: _____ (date results of confirmatory testing were reported by lab)

1. What confirmatory testing was done by your office? Please attach copy of lab results.

Date of draw: _____

- ☐ Hemoglobin Electrophoresis
- ☐ HPLC
- ☐ CBC
- ☐ Mutation Analysis (Genotype): _____ /_____
  Allele #1 Allele #2

2. Choose Diagnosis:

HGB01 ☐ Expired, If cause of death is known, choose the appropriate diagnosis below

HGB10 ☐ Disease, Hemoglobin S + S (sickle cell disease)
HGB11 ☐ Disease, Hemoglobin S + C disease
HGB12 ☐ Disease, Hemoglobin S + D disease
HGB13 ☐ Disease, Hemoglobin S + E disease
HGB14 ☐ Disease, Hemoglobin S + beta thalassemia disease
HGB15 ☐ Disease, Hemoglobin S + other variant disease

HGB16 ☐ Disease, Hemoglobin C + C disease
HGB17 ☐ Disease, Hemoglobin C + D disease
HGB18 ☐ Disease, Hemoglobin C + E disease
HGB19 ☐ Disease, Hemoglobin C + beta thalassemia disease
HGB20 ☐ Disease, Hemoglobin C + other variant disease

HGB21 ☐ Disease, Hemoglobin D + D disease
HGB22 ☐ Disease, Hemoglobin D + E disease
HGB23 ☐ Disease, Hemoglobin D + beta thalassemia disease

HGB24 ☐ Disease, Hemoglobin E + E disease
HGB25 ☐ Disease, Hemoglobin E + beta thalassemia/other variant disease

HGB26 ☐ Disease, Hemoglobin H + alpha thalassemia disease

HGB28 ☐ Disease, Hemoglobin F only + beta thalassemia disease

HGB29 ☐ Disease, not on NBS panel. Specify: _____
HGB30 ☐ Inconclusive, Hemoglobinopathy

HGB40 ☐ No disease
HGB41 ☐ No disease, Hemoglobin S trait (sickle trait)
HGB42 ☐ No disease, Hemoglobin C trait
HGB43 ☐ No disease, Hemoglobin D trait
HGB46 ☐ No disease, Hemoglobin E trait
HGB47 ☐ No disease, Hemoglobin other variant trait
HGB48 ☐ No disease, Alpha thalassemia trait

COMMENTS: _____

PROVIDER'S SIGNATURE: _____ DATE: _____

PRINT NAME and TITLE: _____ FACILITY/PRACTICE: _____

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