NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208
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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 69-1.5e.
Note: Newborn Screening results do not constitute a diagnosis. Confirmatory testing is required.

NEWBORN INFORMATION:

Name at Time of Birth: _____

Other Names (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:

- ☐ No evidence of immune dysfunction
- ☐ Severe combined immunodeficiency, specify gene and mutations, if available_____
- ☐ Idiopathic T cell lymphopenia
- ☐ DiGeorge syndrome
- ☐ Other, specify_____

☐ **PLEASE COMPLETE OR CHECK BOX IF CONFIRMATORY TESTING IS ATTACHED**

CBC WITH DIFFERENTIAL DATE: **FLOW CYTOMETRY DATE:**

	RESULTS	NORMAL RANGE		RESULTS	NORMAL RANGE
WBC			% T cells(CD3)		
RBC			% B cells(CD19)		
HgB			% NK cells(CD16CD56)		
Hct			% Helper cells(CD4)		
Platelet Ct.			% Suppressor cells(CD8)		
ABS Neutrophils			Total lymphocytes(CD45)		
ABS Lymphocytes			ABS T cells(CD3)		
ABS Monocytes			ABS B cells(CD19)		
ABS Eosinophils			ABS NK cells(CD16CD56)		
ABS Basophils			ABS Helper cells(CD4)		
			ABS Suppressor cells(CD8)		

Was the patient referred for transplant evaluation? Yes No **MITOGENS DATE**: _____ Normal Abnormal
Where were they referred? _____ PHA: S.I. %NC Results _____Normal Range_____
ConA: S.I. %NC Results _____Normal Range_____
PWM: S.I. %NC Results _____Normal Range_____

Comments: _____

Physician signature: _____ **Date:** _____

Print Name_____ **Facility/practice:** _____