NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208
Phone: (518)473-7552 Fax (Thyroid, CF, CAH only): (518) 473-8627
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CYSTIC FIBROSIS 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: 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 attach sweat test, and any other confirmatory test results, and indicate a diagnosis.

DATE OF TEST*	TEST*	RESULT	NORMAL RANGE *per CFF Guidelines
	Sweat Chloride		Up to 6 months: less than 30 mmol/L Older than 6 months: less than 40 mmol/L
	Sweat Chloride		Up to 6 months: less than 30 mmol/L Older than 6 months: less than 40 mmol/L

***Note: If other than CFF Guidelines are used for the normal sweat chloride range, check here [ ] and attach a copy of the results with normal range clearly indicated.**

DIAGNOSIS - PLEASE CHOOSE ONE OF THE FOLLOWING:

[ ] Cystic Fibrosis: sweat test result: ≥ 60 mmol/L or 2 CF causing mutations
[ ] Cystic Fibrosis Possible: sweat test result: up to 6 mos: 30-59, older than 6 mos: 40-59 mmol/L
[ ] CFTR-related Metabolic Syndrome (CRMS)
[ ] Cystic Fibrosis very unlikely: sweat test results fall within the normal ranges indicated above
[ ] Carrier ï Genetic Counseling is recommended if not already completed.

Was independent mutation analysis performed? [ ] No [ ] Yes Mutations detected:

Meconium ileus/plug? [ ] No [ ] Yes - **Fecal Elastase** [ ]No [ ]Yes - **Results**: [ ]Normal [ ]Indeterminate [ ]Abnormal

If confirmatory testing has not occurred, please indicate date of sweat test appointment: _____

Comments: _____

Physician signature: _____ **Date:** _____ **Phone #:**_____

Print name: _____ **Facility/practice:** _____