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: (518)474-0405
E-mail: nbsinfo@health.ny.gov

INHERITED METABOLIC DISORDER DIAGNOSIS FORM

Dear Doctor:
Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible.
Attach Clinical Laboratory results including any available mutation analysis.
Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.5e.

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 #: _____

Galactosemia

GALT01 **[ ]** Expired. If cause of death is known, choose the appropriate diagnosis below.
GALT10 **[ ]** Disease, Galactosemia ï classical
GALT11 **[ ]** Disease, Galactosemia ï variant
GALT29 **[ ]** Disease, not on NBS panel. Specify: _____
GALT30 **[ ]** Inconclusive, Galactosemia
GALT40 **[ ]** No disease
GALT41 **[ ]** No disease, transient abnormality due to prematurity/TPN
GALT49 **[ ]** No disease, polymorphisms only
GALT71 **[ ]** Other, maternal disease or medication

Biotinidase

BIOT01 **[ ]** Expired. If cause of death is known, choose the appropriate diagnosis below.
BIOT10 **[ ]** Disease Biotinidase ï classical
BIOT11 [ ] Disease ï partial Biotinidase deficiency
BIOT29 **[ ]** Disease, not on NBS panel. Specify: _____
BIOT30 **[ ]** Inconclusive, Biotinidase
BIOT40 **[ ]** No disease
BIOT41 **[ ]** No disease, transient abnormality due to prematurity/TPN
BIOT71 **[ ]** Other, maternal disease or medication

COMMENTS: _____

PHYSICIAN'S SIGNATURE: _____DATE:_____

PRINT NAME: _____