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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CONGENITAL ADRENAL HYPERPLASIA DIAGNOSIS FORM

Dear Doctor:
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 #: ______________________

1. ATTACH CLINICAL LABORATORY RESULTS

Date of Test	Test	Result	Normal Range (required)
	17-OHP		

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

2. CHOOSE ONE DIAGNOSIS

CAH01 [ ] Expired, If cause of death is known, choose the appropriate diagnosis below
CAH10 [ ] Disease, Congenital adrenal hyperplasia ó 21-hydroxylase deficiency (classic, salt wasting)
CAH11 [ ] Disease, Congenital adrenal hyperplasia ó 21-hydroxylase deficiency (classic, simple virilizing)
CAH12 [ ] Disease, Congenital adrenal hyperplasia ó 21-hydroxylase deficiency (nonclassic)
CAH13 [ ] Disease, Congenital adrenal hyperplasia ó other enzyme deficiency
CAH29 [ ] Disease, not on NBS panel ó Specify: ______________________
CAH30 [ ] Possible disease, CAH
CAH40 [ ] No disease
CAH41 [ ] No disease, transient elevation due to prematurity/TPN
CAH45 [ ] No disease, Carrier
CAH71 [ ] Other, maternal disease or medication

COMMENTS: ______________________

PHYSICIAN'S SIGNATURE: ______________________**DATE:**______________

PRINT NAME: ______________________**FACILITY/PRACTICE:** ______________________