New York State Department of Health
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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. **Screening results do not constitute a diagnosis. Confirmatory testing is required**. Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.7c.

NEWBORN INFORMATION

Name at birth: _____
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.

Test	Date of test(s)	Result(s)	Normal range per CFF guidelines
Sweat chloride			< 30 mmol/L
Sweat chloride			< 30 mmol/L

Initial consult date by CF Specialist: _____
If confirmatory testing has not occurred, please indicate date of sweat test appointment: _____

CLINICAL FINDINGS:
Meconium ileus/plug: [ ] No [ ] Yes
Fecal elastase: [ ] No [ ] Yes - Results: [ ] Normal [ ] Abnormal
Other clinical findings suggestive of disease: _____
If independent, confirmatory *CFTR* sequence and/or del/dup analysis was performed, list variants detected, including cis/trans status if known: _____

DIAGNOSIS: Please choose one of the following and provide the corresponding diagnosis date:
[ ] Disease, Cystic Fibrosis
[ ] CRMS / CFSPID
[ ] Variants in cis confirmed by independent testing of parents; attach report if not performed at Wadsworth
[ ] Other (describe) _____

Diagnosis date: _____

Was this newborn previously known to be at increased risk for this disorder?
[ ] No [ ] Yes, family history [ ] Yes, prenatal testing [ ] Yes, preconception testing

FOLLOW-UP PLAN:
[ ] Assessment complete, no further follow-up is indicated: _____
[ ] Infant will continue to be followed by CF Center. Next appt date: _____

Comments: _____

Physician signature: _____ Date: _____

Print name: _____ Facility/practice: _____