

**NEWBORN SCREENING PROGRAM**  
**New York State Department of Health**  
**David Axelrod Institute, 120 New Scotland Ave.**  
**Albany, NY 12208**  
**Phone: (518) 473-7552 Fax: (518) 473-8627**  
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**Website: http://www.wadsworth.org/newborn/**

**HYPOTHYROID 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 69-1.7c.

**Note: Screening results do not constitute a diagnosis. Confirmatory testing is required.**

**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 #: \_\_\_\_\_

**1. ATTACH CLINICAL LABORATORY RESULTS**

| DATE OF TEST | TEST            | RESULTS (pre-treatment) | NORMAL RANGE (required) |
|--------------|-----------------|-------------------------|-------------------------|
|              | <b>Total T4</b> |                         |                         |
|              | <b>Free T4</b>  |                         |                         |
|              | <b>TSH</b>      |                         |                         |
|              | <b>Other:</b>   |                         |                         |

**2. Treatment Started?**  No  
 Yes – Date of first dose: \_\_\_\_\_

**3. Thyroid Scan?**  No  
 Yes – Results: \_\_\_\_\_

**4. Endocrine follow-up?**  No  
 Yes – Name of Endocrinologist: \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Date of Next Appointment:** \_\_\_\_\_

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**5. CHOOSE ONE DIAGNOSIS (for possible disease, please see bottom of page):**

**Hypothyroidism**

- TH01  Expired, If cause of death is known, choose the appropriate diagnosis below
- TH10  Disease, Primary congenital hypothyroidism - uncompensated (low FT4, elevated TSH)
- TH12  Disease, Primary congenital hypothyroidism – athyreosis, agenesis (including partial) or dysplasia
- TH13  Disease, Congenital hypothyroidism – compensated (normal FT4, elevated TSH)
- TH15  Disease, Ectopic thyroid – lingual or sublingual
- TH16  Disease, Dysmorphogenesis – defect in hormone synthesis
- TH18  Disease, Goiterous hypothyroidism – enlarged gland
- TH20  Disease, Central hypothyroidism – second or tertiary
- TH22  Disease, Central hypothyroidism - panhypopituitarism
- TH28  Disease, Thyroid disease of other etiology
- TH29  Disease, not on NBS panel – Specify: \_\_\_\_\_
  
- TH30  Possible disease, persistent hypothyroxinemia (low FT4, normal TSH) – on treatment or followed – see below
- TH31  Possible disease, hypothyroxinemia of prematurity – on treatment or followed – see below
- TH32  Possible disease, persistent hyperthyrotropinemia (normal FT4, borderline TSH) – see below  
– on treatment or followed
- TH33  Possible disease, hyperthyrotropinemia of prematurity – on treatment or followed – see below
  
- TH40  No disease, Euthyroid
- TH41  No disease, Euthyroid – sick baby syndrome
- TH42  No disease, Hypothyroxinemia of prematurity
- TH43  No disease, Hyperthyrotropinemia of prematurity
- TH45  No disease, Thyroid binding globulin deficiency (TBG)
- TH47  No disease, Euthyroid, transient, previous hypothyroxinemia
- TH48  No disease, Euthyroid, transient, previous hyperthyrotropinemia
- TH71  Other, maternal antibodies
- TH72  Other, maternal medication
- TH73  Other, maternal – iodine deficiency/excess
- TH74  Other, Acquired hypothyroidism

**POSSIBLE DISEASE (Diagnostic work-up still in progress)?** \_\_\_\_\_

**If yes, please provide date of next visit/labs in comments below and ensure current labs are provided on page 1.**

**COMMENTS:** \_\_\_\_\_

**PHYSICIAN’S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_ **FACILITY/PRACTICE:** \_\_\_\_\_