

NEWBORN SCREENING PROGRAM
New York State Department of Health
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INHERITED METABOLIC DISORDER – UREA CYCLE - 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 69-1.7c.

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 #: _____

Argininemia

- ARG 01 Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
- ARG 10 Disease Argininemia (ARG)
- ARG 29 Disease, not on NBS panel: Specify: _____
- ARG 30 Inconclusive/possible (work-up in progress), ARG
- ARG 40 No disease
- ARG 41 No disease transient elevation due to prematurity/TPN
- ARG 71 Other, Maternal disease or medication

ASA/Citrullinemia

- CIT 01 Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
- CIT 10 Disease, Citrullinemia 1
- CIT 11 Disease, Citrullinemia 2 (citrin deficiency)
- CIT 29 Disease, not on NBS panel: Specify: _____
- CIT 30 Inconclusive/possible (work-up in progress), ASA/CIT
- CIT 40 No disease
- CIT 41 No disease transient abnormality due to prematurity/TPN
- CIT 49 No disease, polymorphisms only
- CIT 71 Other, Maternal disease or medication

Was this newborn previously known to be at increased risk for this disorder?

No Yes, family history Yes, prenatal testing Yes, preconception testing

COMMENTS _____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____