NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute, 120 New Scotland Ave.
Albany, NY 12208
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Website: http://www.wadsworth.org/newborn/

MPS I REFERRAL DIAGNOSIS FORM

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: Newborn 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. Abnormal clinical findings/symptoms? [ ] Yes [ ] No

If yes, please specify:_____

2. Maternal Ethnicity _____ Paternal Ethnicity _____

3. Confirmatory testing

DATE	TEST	Newborn's Results	Normal Range
	IDUA enzyme analysis		
	Urine GAGs		

4. Select genotype:
- **[ ]** 2 pathogenic variants
- **[ ]** 1 pathogenic variant, ≥ 1 VUS
- **[ ]** 1 pathogenic variant
- **[ ]** 2 VUS
- **[ ]** 1 VUS
- **[ ]** Pseudodeficiency Allele(s)

5. Select diagnosis:
- **[ ]** Expired, no diagnosis
- **[ ]** Severe MPS I
- **[ ]** Attenuated MPS I
- **[ ]** Possible MPS I disease
- **[ ]** Carrier of MPS I disease

5.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:_____

PRINT NAME: _____FACILITY/PRACTICE: _____