NEWBORN SCREENING PROGRAM
New York State Department of Health
Wadsworth Center, David Axelrod Institute
120 New Scotland Avenue
Albany, NY 12208
Phone: (518)473-7552 Fax: (518)474-0405
E-mail: nbsinfo@health.ny.gov

CYSTIC FIBROSIS REFERRAL – APPOINTMENT CONFIRMATION

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 #: ______________________________

Appointment for Sweat Test Scheduled: Yes No

Date of Appointment: ______________________

Comments: ____

Signature: ________________________________ Date: _________________

Print name: ________________________________

Thank you for your cooperation with our follow-up efforts. If further information is needed, please call (518) 473-7552.