NEWBORN SCREENING PROGRAM
New York State Department of Health
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Albany, NY 12208
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HEMOGLOBINOPATHY DIAGNOSIS FORM

Dear Provider:
Please complete Part I of this form and return it to the Newborn Screening Program (NBSP) as soon as possible. Please submit a repeat newborn screening specimen or send a copy of your independent laboratory results. Confirmatory testing is required, as specified in Title 10 NY Code of Rules and Regulations subpart 69-1.7c. Please complete and return Part II of this form when a diagnosis is confirmed.

Name at birth: _____ AKA: _____

Date of birth: _____ **Single Birth □ Twin A □ Twin B □ Other _____**

Mother's name: _____

Hospital of birth: _____ Medical Record #: _____

Lab ID/Accession #: _____

Part I. (To be completed and returned as soon as possible)

1. What confirmatory testing was done and/or is planned by your office? Please send results when available.

Date of draw: _____
[ ] Hemoglobin Electrophoresis
[ ] HPLC
[ ] CBC
[ ] Genetic Testing (Gene Sequencing/Mutation Analysis)

[ ] Repeat Newborn Screen
[ ] Other, Specify: _____

2. Does this baby have an appointment at a Specialty Care Center (SCC)?

[ ] Yes, center name and phone number: _____

Date of initial appointment: _____

[ ] No specialist appointment. Why? Provide detailed comments on attempts to reach family and any issues the office or family is encountering:

_____

_____

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

COMMENTS: _____

PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME and TITLE: _____ FACILITY/PRACTICE: _____

Name at birth: _____ AKA: _____ Date of birth: _____

Mother's name: _____ Lab ID/Accession #: _____

Part II. (To be completed and returned by specialist when a diagnosis is confirmed)

Diagnosis Date: _____ (date results of confirmatory testing were reported by lab)

1. What confirmatory testing was done by your office? Please attach copy of lab results.

Date of draw: _____

[ ] Hemoglobin Electrophoresis

[ ] HPLC

[ ] CBC

[ ] Mutation Analysis (Genotype): _____ /_____

Allele #1 Allele #2

2. Choose Diagnosis:

HGB01 [ ] Expired, If cause of death is known, choose the appropriate diagnosis below

HGB10 [ ] Disease, Hemoglobin S + S (sickle cell disease)
HGB11 [ ] Disease, Hemoglobin S + C disease
HGB12 [ ] Disease, Hemoglobin S + D disease
HGB13 [ ] Disease, Hemoglobin S + E disease
HGB14 [ ] Disease, Hemoglobin S + beta thalassemia disease
HGB15 [ ] Disease, Hemoglobin S + other variant disease

HGB16 [ ] Disease, Hemoglobin C + C disease
HGB17 [ ] Disease, Hemoglobin C + D disease
HGB18 [ ] Disease, Hemoglobin C + E disease
HGB19 [ ] Disease, Hemoglobin C + beta thalassemia disease
HGB20 [ ] Disease, Hemoglobin C + other variant disease

HGB21 [ ] Disease, Hemoglobin D + D disease
HGB22 [ ] Disease, Hemoglobin D + E disease
HGB23 [ ] Disease, Hemoglobin D + beta thalassemia disease

HGB24 [ ] Disease, Hemoglobin E + E disease
HGB25 [ ] Disease, Hemoglobin E + beta thalassemia/other variant disease

HGB26 [ ] Disease, Hemoglobin H + alpha thalassemia disease

HGB28 [ ] Disease, Hemoglobin F only + beta thalassemia disease

HGB29 [ ] Disease, not on NBS panel. Specify: _____
HGB30 [ ] Inconclusive, Hemoglobinopathy

HGB40 [ ] No disease
HGB41 [ ] No disease, Hemoglobin S trait (sickle trait)
HGB42 [ ] No disease, Hemoglobin C trait
HGB43 [ ] No disease, Hemoglobin D trait
HGB46 [ ] No disease, Hemoglobin E trait
HGB47 [ ] No disease, Hemoglobin other variant trait
HGB48 [ ] No disease, Alpha thalassemia trait

COMMENTS: _____

PROVIDER'S SIGNATURE: _____ DATE: _____

PRINT NAME and TITLE: _____ FACILITY/PRACTICE: _____