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

Diagnosis Date:__________________

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:** _____________________________