NEWBORN SCREENING PROGRAM
New York State Department of Health
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SEVERE COMBINED IMMUNODEFICIENCY 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 #: _____

PLEASE INDICATE A DIAGNOSIS:

Diagnosis Date:_____

- ❑ Expired. If cause of death is known, choose the appropriate diagnosis below.
- ❑ No evidence of immune dysfunction
- ❑ Severe combined immunodeficiency (Abs. T cells < 300), specify gene and mutation(s) if available: _____
- ❑ Leaky SCID/Omenn syndrome, (300 < Abs. T cells < 1500, abnormal mitogen studies) specify gene and mutation(s) if available: _____
- ❑ Variant SCID (300 < Abs. T cells < 1500, normal mitogens/mitogens not completed)
- ❑ Syndrome with T cell impairment, specify below:
  - ❑ DiGeorge Syndrome
  - ❑ CHARGE Syndrome
  - ❑ Down Syndrome
  - ❑ Other: please specify_____
- ❑ Idiopathic T cell lymphopenia
  Will additional testing be done to see if issue resolves? □Yes □No
  Expected date of additional testing:_____
- ❑ Secondary T cell lymphopenia
  - ❑ Heart defect/surgery
  - ❑ Gastroschisis
  - ❑ Thymectomy
  - ❑ Other, please specify:_____
- ❑ Other, please specify: _____

** Please attach confirmatory testing **

Were mitogens done? □Yes □No **DATE**: _____
□ Normal □ Abnormal

Was the patient referred for transplant evaluation? □Yes □No
Where were they referred? _____

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 signature: _____Date: _____

Print Name_____ Facility/practice: _____