NEWBORN SCREENING PROGRAM
New York State Department of Health
David Axelrod Institute, 120 New Scotland Ave.
Albany, NY 12208
Phone: (518) 473-7552 Fax: (518) 474-0405
E-mail: nbsinfo@health.ny.gov
Website: http://www.wadsworth.org/newborn/

INHERITED METABOLIC DISORDER – UREA CYCLE - DIAGNOSIS FORM

Dear Doctor:
Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible.
Attach Clinical Laboratory results including any available mutation analysis.
Your response is required, as specified in Title 10 New York Code of Rules and Regulations subpart 69-1.7c.

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 #: _____

Diagnosis Date:_____

Argininemia

ARG 01	[ ] Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
ARG 10	[ ] Disease Argininemia (ARG)
ARG 29	[ ] Disease, not on NBS panel: Specify: _____
ARG 30	[ ] Inconclusive/possible (work-up in progress), ARG
ARG 40	[ ] No disease
ARG 41	[ ] No disease transient elevation due to prematurity/TPN
ARG 71	[ ] Other, Maternal disease or medication

ASA/Citrullinemia

CIT 01	[ ] Expired, no diagnosis. If cause of death is known, choose the appropriate diagnosis below
CIT 10	[ ] Disease, Citrullinemia 1
CIT 11	[ ] Disease, Citrullinemia 2 (citrin deficiency)
CIT 29	[ ] Disease, not on NBS panel: Specify: _____
CIT 30	[ ] Inconclusive/possible (work-up in progress), ASA/CIT
CIT 40	[ ] No disease
CIT 41	[ ] No disease transient abnormality due to prematurity/TPN
CIT 49	[ ] No disease, polymorphisms only
CIT 71	[ ] Other, Maternal disease or medication

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:**_____

Enclosures **LEIU30**