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

SPINAL MUSCULAR ATROPHY DIAGNOSIS FORM

Please complete this form in its entirety and return it to the Newborn Screening Program as soon as possible. **Screening results do not constitute a diagnosis. Confirmatory testing is required.** 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 #: _____

[ ] Independent confirmatory testing - Please attach confirmatory test results and indicate a diagnosis below.

Date of Test	Test	Test Method	Results
	SMN1 genotype		
	SMN2 genotype/copy number		
	Other, specify		

Initial consult date by Neuromuscular specialist: _____
If confirmatory testing has not occurred, please indicate date of appointment: _____

DIAGNOSIS: **Diagnosis Date:_____**
[ ] Confirmed SMA; Abnormal clinical findings/symptoms: [ ] Yes [ ] No Describe_____
[ ] Expired, diagnosis unknown
[ ] Other, specify _____

FOLLOW-UP PLAN:
Treatment plan: [ ] Nusinersen/Spinraza [ ] Gene therapy/Zolgensma [ ] Other _____
[ ] Assessment complete, no further follow-up is indicated: _____
[ ] Infant will continue to be followed by Neuromuscular Center. Next appointment date: _____

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

Maternal Race/Ethnicity _____ Paternal Race/Ethnicity _____
Comments: _____

Physician signature: _____ Date: _____

Print name: _____ Facility/Practice: _____