OKLAHOMA
State Department
of Health

Newborn Screening Report Form

Infant's Name:_____Infant's Birth Date_____/_____/ _____

Newborn Screening Program Lab #:_____Mother's Name:_____

[ ] Diagnosis pending, Follow-up Plan:

Final Diagnosis (please attach CONFIRMATION LAB RESULTS)
[ ] Normal
[ ] Trait Condition (specify carrier status)_____
[ ] Classic Galactosemia (GG phenotype/genotype)
[ ] Duarte/Galactosemia Compound Heterozygote (DG phenotype/genotype)
[ ] Congenital Hypothyroidism
[ ] Congenital Adrenal Hyperplasia due to 21-Hydroxylase Deficiency
[ ] Cystic Fibrosis
[ ] Amino Acid Disorder (specify type)_____
[ ] Fatty Acid Oxidation Disorder (specify type)_____
[ ] Organic Acid Disorder (specify type)_____
[ ] Mucopolysaccharidosis Type I (specify type)_____
[ ] Pompe (specify type)_____
[ ] Sickle Cell Disease (specify type)_____
[ ] Hemoglobin disease (specify type)_____
[ ] Biotinidase Deficiency (specify type)_____
[ ] Other (specify)_____

Treatment Indicated? [ ] yes [ ] no
Date treatment started_____/_____/ _____

Referred to pediatric sub-specialist (specify name):
[ ] Endocrinologist:_____
[ ] Metabolic Specialist/Geneticist:_____
[ ] Neurologist:_____

Date of first clinic visit to specialist:____/____/ ____
[ ] Hematologist:_____
[ ] Pulmonologist:_____

Family referred for (check all that apply):
[ ] Genetic counseling (check provider):
___Geneticist _Other (specify)_____
[ ] Enrollment in Newborn Screening Long-term Follow-up Program
[ ] Early Intervention Services

Print Physician's Name_____Telephone_____/_____/_____

Physician Signature_____Date_____/_____/ _____

Mail or Fax this follow-up form with complete diagnostic information and confirmation lab results to:
Oklahoma State Department of Health
ATTN: Newborn Screening Program Coordinator
123 Robert S. Kerr Ste 1702
Oklahoma City, OK 73102-6406
Fax: (405) 900-7556

Questions or Referral Information
Phone: (405) 426-8220
(800) 766-2223