CONFIRMED CASE REPORTING FORM
ODH LABORATORIES, NEWBORN SCREENING PROGRAM

Physician Name	**Address**	**Date**
Baby's Last Name	**First Name**	**Date of Birth**
Mother's Name	**Birth Hospital**	**NBS kit number**

Final diagnosis Reported: (check the box)

- ☐ Argininemia
- ☐ Biotinidase Deficiency
- ☐ Carnitine Palmitoyl Transferase Deficiency Type II
- ☐ Citrullinemia
- ☐ Congenital Hypothyroidism
- ☐ Galactosemia
- ☐ Glutaric Acidemia Type II
- ☐ 3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency
- ☐ Isobutyryl-CoA Dehydrogenase Deficiency
- ☐ 3-Ketothiolase Deficiency
- ☐ Maple Syrup Urine Disease (MSUD)
- ☐ 2-Methylbutryl-CoA Dehydrogenase Deficiency
- ☐ Methylmalonic Acidemia
- ☐ Phenylketonuria (PKU)
- ☐ Short Chain Acyl-CoA Dehydrogenase Deficiency
- ☐ Other Hemoglobinopathies (Please specify) _____
- ☐ Tyrosinemia
- ☐ Severe Combined Immune Deficiency
- ☐ Argininosuccinic Acidemia
- ☐ Carnitine/Acylcarnitine Translocase Deficiency
- ☐ Carnitine Uptake Defect
- ☐ Congenital Adrenal Hyperplasia
- ☐ Cystic Fibrosis
- ☐ Glutaric Acidemia Type I
- ☐ Homocystinuria
- ☐ Hypermethioninemia
- ☐ Isovaleric Acidemia
- ☐ Long Chain Hydroxyacyl-CoA Dehydrogenase Deficiency
- ☐ Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)
- ☐ 3-Methylcrotonyl-CoA Carboxylase Deficiency
- ☐ Multiple CoA Carboxylase Deficiency
- ☐ Propionic Acidemia
- ☐ Sickle Cell Disease
- ☐ Trifunctional Protein Deficiency
- ☐ Very Long Chain Acyl-CoA Dehydrogenase Deficiency
- ☐ Other _____

Confirmatory Test Results:

Please return a copy of this form with documentation of the final diagnosis, confirming laboratory results and treatment information to the Ohio Department of Health Laboratories. Address: 8995 East Main Street, Bldg 22, Reynoldsburg OH 43068. Fax # 614-644-4648. Thank you for your time in sharing this information.