

Diagnostic Evaluation Report Form

DOE, BABY BOY

Health Card Number: 0123456789	D.O.B.: 2008-01-01
ONSL Accession Number: 200801010001	Date of Report: 2008-06-16
Infant's HCP*: Smith, Dr. J	
Submitting Facility: Children's Hospital of Eastern Ontario	
Referring Physician: Dr. P. Chakraborty	

Screen Positive for: PKU	Screening Phenylalanine: 400
Treatment Centre: CHEO NBS Centre	Screening P/T: 3

RETRIEVAL AND CLINICAL STATUS

Date of first contact with family:		Symptomatic (y/n)	
Date of retrieval for diagnostic evaluation:		Gaining weight (y/n)	
Infant's name (if different from above):		Hospitalized (y/n)	
Infant's HCP (if different from above):		Well / Unwell / Deceased	

DIAGNOSIS:

Results of Initial Investigations (Please complete form and/or attach reports)

	Result (unit)	Reference Interval
Plasma Phenylalanine		
Plasma Tyrosine		
Urinary Pterins		
DHPR assay		
Bioplerin Loading Test (phe > 600)	(attach reports)	
Other		

After initial evaluation, decision made to (CHECK ONE):

	Decision	Date decision made (YY/MM/DD)
<input type="checkbox"/>	Discharge	
<input type="checkbox"/>	Continue to follow with no treatment	
<input type="checkbox"/>	Initiate Treatment	

Definitive Diagnosis:

<input type="checkbox"/>	Not Affected
<input type="checkbox"/>	Classical PKU (Initial Phe > 1200) Mild Hyperphenylalaninemia (Initial Phe 120-600)
<input type="checkbox"/>	Bioplerin Responsive Classical PKU (Initial Phe > 1200) DHPR
<input type="checkbox"/>	Mild PKU (Initial Phe 600-1200) GTP Cyclohydrolase Deficiency
<input type="checkbox"/>	Classical PKU (Initial Phe > 1200) PCD Deficiency
<input type="checkbox"/>	Bioplerin Responsive Classical PKU (Initial Phe > 1200) SR Deficiency
<input type="checkbox"/>	Mild PKU (Initial Phe 600-1200) PTPS Deficiency
<input type="checkbox"/>	Bioplerin Responsive Mild PKU (Initial Phe 600-1200)
<input type="checkbox"/>	Other (Specify: _____)

FAMILY HISTORY (IF PROBAND IS CONFIRMED TO BE AFFECTED)

Number of Sibs (total): _____

Number of Sibs (affected): _____

Any deceased sibs, specify number?: _____

Other affected family members (specify relationship to patient):