Diagnostic Evaluation Report Form (DERF) – BILIARY ATRESIA

Infant's Name:		**Infant's OHIP:**	
Infant's DOB:	(YYYY/MM/DD)	**Infant's Sex:**	
Birth Parent/Guardian's Name:		**NSO Identifier:**	
GI Specialist:		**Date of Referral:**	(YYYY/MM/DD)
Treatment Centre:			

CONFIRMATORY BILIRUBIN TESTING:		
INITIAL Screening Bilirubin, Total and Direct/Conjugated	Date: (YYYY/MM/DD)	Total_____ Direct_____ Conjugated_____ **Comments/Findings:**
REPEAT Screening Bilirubin, Total and Direct/Conjugated	Date: (YYYY/MM/DD)	Total_____ Direct_____ Conjugated_____ **Comments/Findings:**

SECOND TIER TESTING:

	Investigations	**Date:**	**Comments/Findings:**
☐	Ultrasound	(YYYY/MM/DD)	
☐	HIDA Scan	(YYYY/MM/DD)	
☐	Cholangiogram	(YYYY/MM/DD)	
☐	Liver Biopsy	(YYYY/MM/DD)	
☐	2nd Tier Blood tests	(YYYY/MM/DD)	Please specify: _____
☐	Alagille Syndrome Testing	(YYYY/MM/DD)	REQUESTED BY GI specialist ☐ Yes ☐ No
☐	Cholestasis Gene Panel	(YYYY/MM/DD)	REQUESTED BY GI specialist ☐ Yes ☐ No
☐	OTHER:	(YYYY/MM/DD)	

Please complete both pages of this form.

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NEWBORN SCREENING **ONTARIO**
DÉPISTAGE NÉONATAL **ONTARIO**

BILIARY ATRESIA
ATRÉSIE DES VOIES BILIAIRES

DEFINITIVE DIAGNOSIS *(complete date and **check one**):*			**Date diagnosis made:** _____
◯	Biliary Atresia		
◯	Alagille Syndrome	◯	Alpha-1 anti-trypsin deficiency
◯	Endocrine disorder: ☐Panhypopituitarism	◯	Inborn error of metabolism: ◯ Galactosemia ◯ Tyrosinemia ◯ Other: _____
◯	Cystic fibrosis	◯	Bile acid synthetic defect
◯	Obstructive gallstones		
◯	Structural Abnormality: ☐ Choledochal cyst ☐ Other: _____	◯	Progressive Familial Intrahepatic Cholestasis (PFIC)
◯	TORCH Specify: _____	◯	Other Infection: _____ _____ _____
◯	Parenteral Nutrition Associated Cholestasis (PNAC)	◯	Lost to Follow up
◯	No disease identified	◯	Other
◯	Idiopathic cholestasis		
◯	Infant deceased prior to diagnosis:	Date of death: _____ Cause of death: _____	

PLAN FOR CARE *(check **one**):*		**Date decision made:**
☐ Discharge	☐ Continue to follow with no treatment	☐ Medical Management
☐ Surgical- KASAI	Procedure Location:	Date of procedure: (YYYY/MM/DD)
☐ Surgical-Transplant	Procedure Location:	Date of procedure: (YYYY/MM/DD)
☐ Surgical- Other	Procedure Location:	Date of procedure: (YYYY/MM/DD)
Comments:		

Form completed by:		Date:	(YYYY/MM/DD)

This form is also posted on the Newborn Screening Ontario website at www.newbornscreening.on.ca/poop

Please fax the completed DERF to **1-833-222-7840** **ATTN: Biliary Atresia Clinical Team**

DERF V7 01/24