Chromosomal Abnormalities Worksheet

California Department of Public Health
Genetic Disease Screening Program

1. NAME OF REPORTING HOSPITAL OR CLINIC
2. YEAR
3. QUARTER

Please provide all available information for each reportable case of a chromosomal abnormality (***ICD-9-CM Codes 758.0-758.9***) in the rows of the grid provided below. In order to help uniquely identify each patient, indicate names and dates of birth (DOB) for the mother and infant and also indicate the gender of the infant. List the name of the birth hospital, especially if the case is being reported by a transfer hospital. State the diagnosis that is being reported by using an *ICD-9-CM Code* and listing the name or nature of the chromosomal abnormality. Please be sure to include any cytogenetic laboratory information and/or documentation associated with a reported case.

INFORMATION ABOUT THE MOTHER		INFORMATION ABOUT THE INFANT			INFORMATION ABOUT THE HOSPITAL AND REPORTED ABNORMALITY			INFORMATION ABOUT THE LABORATORY	
NAME OF MOTHER	DOB OF MOTHER	NAME OF INFANT	DOB OF INFANT	GENDER	NAME OF BIRTH HOSPITAL	ICD-9-CM CODE (758.0-758.9)	ABNORMALITY	NAME OF CYTOGENTIC LAB	SPECIMEN NUMBER

Please contact Jamie Matteson at **(510) 307-8597** or **Jamie.Matteson@cdph.ca.gov** if you have any questions or concerns.

Print Form