# SCID Data Collection Form for SCID Second Tier Testing

**Infant's Name:** **DOB:** **SHL #:**

Does the infant have any congenital anomalies?

Has the infant had any surgeries (type of surgery, date and time)?

If yes, obtain birth time.

Does the infant have any family history of primary immunodeficiency?

Has a CBC with differential been completed or ordered?

If yes, date CBC obtained:

Hgb: Platelets: Lymphocytes: Neutrophils:

WBC: Monocytes: Eosinophils:

Has the infant had a chest X-ray?

If so, were there any rib abnormalities or cardiac abnormalities?

Were prenatal ultrasounds normal?

If abnormal, how?

**Please return this form to the SDNSP by fax: 605-773-5683**

**This clinical information is needed to interpret flow cytometry results (second tier testing).**

Thank you,

The South Dakota Newborn Screening Program

Phone 605-773-3361

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