Congenital Malformations Registry
Confidential Case Report

New York State Department of Health
Bureau of Environmental and Occupational Epidemiology

Type or print clearly using blue or black ink.

Child's Information	**PFI Number**	**Medical Record Number**

Child's Name Last First M.I. **(DOH USE ONLY)**

AKA: If child has been identified by another name(s), enter the name(s)

Address Street City State Zip Code

Date of Birth (month/day/year)	**Birth Status**	**Birthweight** (grams)	**Sex**
__ __ / __ __ / __ __ __ __	☐ Live ☐ Still		☐ Male ☐ Female ☐ Undesignated

Race
☐ White ☐ Black or African American ☐ American Indian/ Alaskan Eskimo ☐ Asian/Pacific Islander ☐ Unknown

Hispanic ☐ Yes ☐ No

Plurality
☐ Single ☐ Twin ☐ Triplet Other, specify _____

If a multiple birth, specify birth order
☐ 1st ☐ 2nd ☐ 3rd Other, specify _____

Born at this facility
☐ Yes ☐ No

If not born at this facility: Hospital of Birth City State Zip Code

Date of Discharge (month/day/year)	**Deceased**	**If deceased, date of death** (month/day/year)	**Foster/Adopted**
__ __ / __ __ / __ __ __ __	☐ Yes ☐ No	__ __ / __ __ / __ __ __ __	☐ Foster ☐ Adopted ☐ No

Diagnostic Information

	ICD Code	Narrative
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____
7)	_____	_____
8)	_____	_____
9)	_____	_____
10)	_____	_____

Chromosome Studies
If yes, Karyotype _____
If pending, cytogenetic lab _____

Parents' Information

Mother's Name Last First M.I. Maiden Name

Date of Birth (month/day/year) __ __ / __ __ / __ __ __ __ **Social Security Number** __ __ __ - __ __ - __ __ __ __

Father's Name Last First M.I.

Date of Birth (month/day/year) __ __ / __ __ / __ __ __ __ **Social Security Number** __ __ __ - __ __ - __ __ __ __

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Reporting Source			
(Stamp Acceptable) Name Street Address City State Zip Code			**Check here if you need more:** ☐ Forms ☐ Envelopes
CMR Registrar	Last	First	Phone
Attending Physician	Last	First	Phone
Pediatrician	Last	First	Phone
Patient transferred from another facility:	(Enter name of facility)		
Patient transferred to another facility:	(Enter name of facility)		

Mail completed form in sealed envelope to:

New York State Department of Health
Bureau of Environmental and Occupational Epidemiology
Congenital Malformations Registry
Flanigan Square, Room 200
547 River Street
Troy, NY 12180-2216
Telephone: (518) 402-7990