

FOLLOW-UP FORM FOR GALACTOSEMIA

Please complete the following:

I. **Diagnosis**

- Classical (G/G) (code 0402)
- D/G (code 0403)
- D/D (code 0409)
- Carrier D/N or  Carrier G/N (code 0409)
- Other (specify) \_\_\_\_\_ (code 0409)
- Unresolved
- Normal (code 1405)

II. **Confirmatory testing**

Date of testing: \_\_\_\_\_

- RBC enzyme analysis
- Urine or  Blood ... for galactose metabolites
- Other tests (specify) \_\_\_\_\_
- Family history  yes (specify) \_\_\_\_\_  no

III. **Treatment**

Date of treatment: \_\_\_\_\_

Formula:

- Nursoy  Isomil
- Prosbee  Nutramigen
- Soyalac

Metabolic/Genetic consult?  Yes  No

Date of first visit: \_\_\_\_\_

**Name(s) of physician(s) evaluating patient:**

Consultant: \_\_\_\_\_

Primary care physician/clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Physician Name: \_\_\_\_\_

LEPFU4 revised 8/5/04 RETURN TO SPECIAL CHILD HEALTH SERVICES