Biotinidase FOLLOW-UP FORM

I. DIAGNOSIS

[ ] Cleared, > **30 % activity** (code 1705)
( ) Carrier, confirmed by DNA testing (code 0706)
[ ] Partial biotinidase deficiency, **10-30% activity** (code 0703)
[ ] Profound biotinidase deficiency, **<10% activity** (code 0702)
Designate when identified (code 0704)
( ) Holocarboxylase synthetase deficiency
( ) Isolated beta-methylcrotontonyl-CoA carboxilase deficiency
( ) Acquired biotinidase deficiency
( ) Other_____

II. RESULTS

Date of 1st retest_____
Enzyme activity results_____ (attach Lab. results)
DNA testing: **( )** Yes, **( )** No
DNA results_____/_____ (attach Lab. results)

Other Diagnostic Tests

Results_____
_____ (attach Lab. results)

III. TREATMENT

Date on Treatment: _____
Date First Seen: _____Primary [ ] Consultant [ ]
Comments: _____

Physician Signature: _____
Printed Physician name: _____
Telephone #:_____Date: **_____**

Return to Special Child Health Services
Thank you for your assistance.

LEPFU9 Revised 4/22/05