www.endogenet.org

Patient Information and Referral Form

PATIENT INFORMATION	REFERRING CLINICIAN INFORMATION
First name: **Family name:** **or Unique Identification number:**	**Name:** **Address:**
Date of birth (dd/mm/yyyy)**:**	
Sex: ☐ Male ☐ Female	
Geographic origin of patient:	**Email:**

DIAGNOSES:

☐ IGHD (Isolated Growth Hormone Deficiency)

☐ MPHD (Multiple Pituitary Hormone Deficiency)

Affected Hormones:	GH	TSH	PRL	ACTH	LH/FSH	ADH	
	☐	☐	☐	☐	☐	☐	
Basal Level:	________	________	________	________	________	________	(Units ?)
Stimulated:	________	________	________	________	________	________	(Units ?)

CLINICAL FEATURES:

Age at diagnosis:

☐ Early infancy (0-1 ys) ☐ Infancy (2-5 ys) ☐ Childhood / Adolescence (6-18 ys)

Symptoms leading to diagnosis:

☐ Prolonged Jaundice	☐ Micropenis	☐ Akromikria	☐ Frontal bossing
☐ Hypoglycaemia	☐ Dry skin	☐ Makroglossia	☐ Truncal obesity
☐ Umbilical hernia	☐ Late dentition	☐ Late fontanelle closure	
Birth Height:__________	☐ Limited neck rotation / Short neck		☐ Projecting eyes
Birth Weight:__________	☐ Growth retardation		☐ Hypothyroidism

Dysmorphic features: ______________________________

Sceletal abnormalities: ______________________________

Neurological deficits: ______________________________

Cardiac malformations: ______________________________

Others: ______________________________

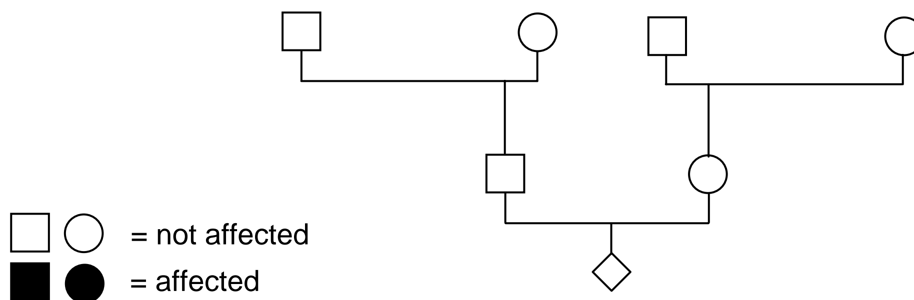
Onset of puberty ☐ not yet ☐ yes, spontaneous at age of __________
☐ Hypogonadism

Menarche not yet ☐ yes, spontaneous ☐ at age of __________

MORPHOLOGICAL ABNORMALITIES			
Imaging of pituitary region performed ?		☐ **yes**	☐ **no**
Pituitary size	☐ small	☐ normal	☐ enlarged
Location of anterior pituitary	☐ in situ	☐ ectopic	
Location of posterior pituitary	☐ in situ	☐ ectopic	

Note: You can send us copies of MRI / CT scans for free evaluation. Especially if morphological abnormalities are present please enclose a copy.

FAMILY
Please give a pedigree drawing below, sign all affected family members and when possible give data for height and weight.



Consanguinity of parents: ☐ **Yes** ☐ **No** ☐ **Unknown**

GROWTH CHART
Please enclose a growth chart with indication of bone age and start and stop of hormone replacement therapy.

HORMONE REPLACEMENT
Please give information about hormone replacement therapy below. For example start, stop and dose of hydrocortisone.

Materials enclosed with this form are:

Blood sample (please provide a minimum of 2 ml EDTA, *do not freeze*) ☐

(DNA sample (please provide a minimum of 50 µg) ☐**)**

MRI-Scans (of the pituitary gland) number provided _ _ _

CT-Scans (of the sella region) number provided _ _ _

Radiographs (of the sella region) number provided _ _ _

Clinical Photographs

Pedigree Drawing

Growth Chart

(Good clinical photographs, growth charts and radiographs can be sent by email as JPEGs)

For further instructions on submission of samples and clinical information see our website at www.endogenet.org or contact:

Prof. Dr. Roland Pfaeffle

Dr. Johannes Weigel

University Hospital for Children and Adolescents

Oststr. 21-25

04317 Leipzig

Tel.: +49-341-9726123

Fax: +49-341-9726349

Email: rpfaeffle@medizin.uni-leipzig.de

johannes.weigel@medizin.uni-leipzig.de