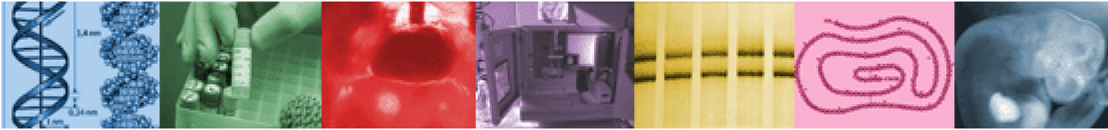


www.endogenet.org

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:

☐ Adrenal insufficiency (Addison disease) ☐ Hypoparathyroidism
☐ Diabetes mellitus ☐ Hypogonadism ☐ Hypoaldosteronism
☐ Pernicious anemia

Pituitary defects:	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	☐ Candidiasis	☐ Extodermal dystrophy	☐ Vitiligo
☐ Hypoglycaemia	☐ Keratopathy	☐ Cholelithiasis	☐ Hepatitis
☐ Umbilical hernia	☐ Asplenia	☐ Chronic atrophic gastritis	
Birth Weight:__________	☐ Alopecia	☐ Dental enamel hypoplasia	
Birth Height:__________	☐ Diarrhea	☐ Malabsorption	

Dysmorphic features: ______________________________

Neurological deficits: ______________________________

Cardiac malformations: ______________________________

Others: ______________________________

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

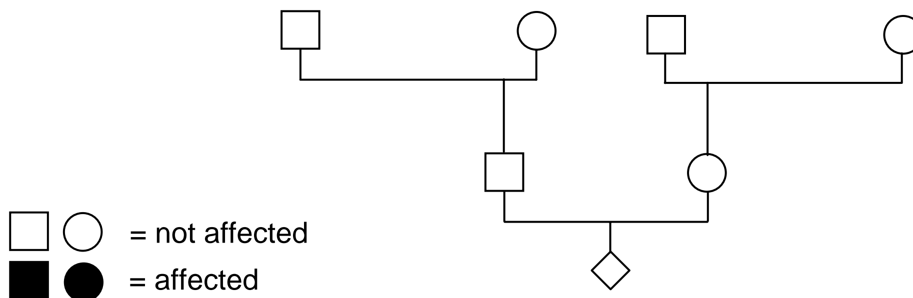
Menarche not yet ☐ yes, spontaneous ☐ at age of ________

MORPHOLOGICAL ABNORMALITIES			
Imaging performed ?	**MRI**	**CT**	**Ultrasonography**
Abdomen / Adrenal Glands			
Genitourinary Tract			
Pituitary			

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	number provided	_ _ _
CT-Scans	number provided	_ _ _
Radiographs	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:

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