



www.endogenet.org

Patient Information and Referral Form

PATIENT INFORMATION	REFERRING CLINICIAN INFORMATION
First name:	Name:
Family name:	
or Unique Identification number:	
Date of birth (dd/mm/yyyy):	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Address:
Geographic origin of patient:	
Email:	

DIAGNOSES:				
<input type="checkbox"/> Nephrogenic Diabetes insipidus	<input type="checkbox"/> Neurohypophyseal Diabetes insipidus			
<u>Substance Level:</u>	ADH	Osmolality	Sodium (Na)	Potassium (K)
Serum: _____	_____	_____	_____	_____ (Units ?)
Urine: _____	_____	_____	_____	_____ (Units ?)
<u>After water deprivation:</u>				
Serum: _____	_____	_____	_____	_____ (Units ?)
Urine: _____	_____	_____	_____	_____ (Units ?)

CLINICAL FEATURES:	
Age at diagnosis:	
<input type="checkbox"/> Early infancy (0-1 ys) <input type="checkbox"/> Infancy (2-5 ys) <input type="checkbox"/> Childhood / Adolescence (6-18 ys)	
Symptoms leading to diagnosis:	
<input type="checkbox"/> Prolonged Jaundice	<input type="checkbox"/> Polydipsia
<input type="checkbox"/> Umbilical hernia	<input type="checkbox"/> Enuresis
Birth Height: _____	<input type="checkbox"/> Mental retardation
Birth Weight: _____	<input type="checkbox"/> Constipation
<input type="checkbox"/> Polyuria	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Lethargy, fatigue	
<u>Additional hormonal deficiencies:</u>	
<input type="checkbox"/> GH	<input type="checkbox"/> TSH
<input type="checkbox"/> Prolactin	<input type="checkbox"/> LH/FSH
<input type="checkbox"/> ACTH	
Dysmorphic features: _____	
Neurological deficits: _____	
Others: _____	
Onset of puberty	<input type="checkbox"/> not yet <input type="checkbox"/> yes, spontaneous at age of _____
	<input type="checkbox"/> Hypogonadism
Menarche	not yet <input type="checkbox"/> yes, spontaneous <input type="checkbox"/> at age of _____

MORPHOLOGICAL ABNORMALITIES

Imaging performed ? MRI CT Ultrasonography

Kidneys Hydronephrosis normal enlarged

Size of posterior pituitary small enlarged missing posterior pituitary

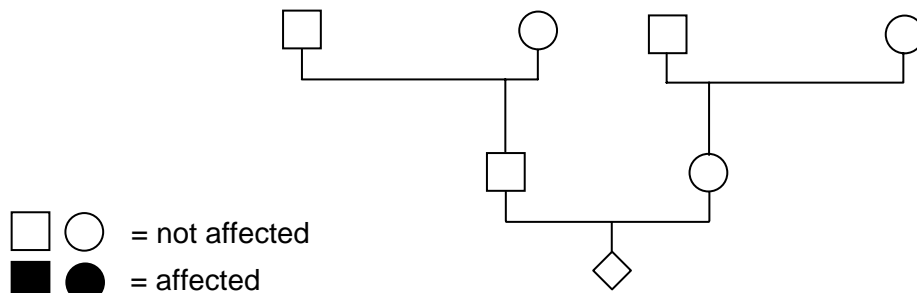
Position of posterior pituitary normal ectopic

Brain malformations Septo optic dysplasia _____

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 desmopressine

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:

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