



www.endogenet.org

Patient Information and Referral Form

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

DIAGNOSES:			
<input type="checkbox"/> Growth Hormone Insensitivity (Laron Syndrome)			
<u>Hormone Level:</u>	GH	IGF-1	IGF-BP3
Basal:	_____	_____	_____ (Units ?)
Stimulated:	_____		_____ (Units ?)
<input type="checkbox"/> Testing of responsiveness to exogenous GH			
DD: <input type="checkbox"/> SGA <input type="checkbox"/> ISS <input type="checkbox"/> GHD <input type="checkbox"/> UTS <input type="checkbox"/> Renal failure			

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"/> Hypoglycaemia Gestational week: _____ Birth Height: _____ Birth Weight: _____	<input type="checkbox"/> Short stature <input type="checkbox"/> Akromikria <input type="checkbox"/> Micropenis <input type="checkbox"/> Saddle nose <input type="checkbox"/> Protruding forehead <input type="checkbox"/> Truncal obesity <input type="checkbox"/> High pitched voice <input type="checkbox"/> Blue sclerae <input type="checkbox"/> Crowded teeth <input type="checkbox"/> Small chin <input type="checkbox"/> Night sweat <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Sunset look
Dysmorphic features:	_____
Skeletal abnormalities:	_____
Neurological deficits:	_____
Cardiac malformations:	_____
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 _____

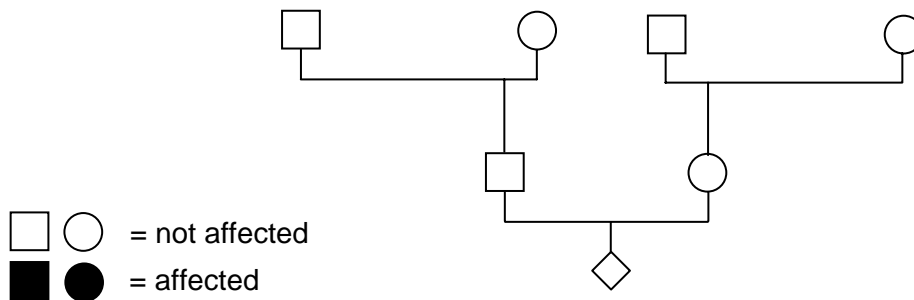
MORPHOLOGICAL ABNORMALITIES

Imaging of pituitary region performed ?	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Pituitary size	<input type="checkbox"/> small	<input type="checkbox"/> normal	<input type="checkbox"/> enlarged
Location of anterior pituitary	<input type="checkbox"/> in situ	<input type="checkbox"/> ectopic	
Location of posterior pituitary	<input type="checkbox"/> in situ	<input type="checkbox"/> 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 growth hormone

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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