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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"/> TSH deficient hypothyroidism						
<u>Hormone</u>	TSH	T3	T4	ft3	ft4	TG
<u>Level :</u> (Units ?)	_____	_____	_____	_____	_____	_____
<u>Positive Thyroid</u>	Thyroid peroxidase		Thyroglobulin		Others	
<u>Autoantibodies:</u>	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<u>Level (Units?):</u>	_____		_____		_____	

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"/> Umbilical hernia <input type="checkbox"/> Poor feeding Birth Height: _____ Birth Weight: _____	<input type="checkbox"/> Growth deceleration <input type="checkbox"/> Dry skin, hair texture <input type="checkbox"/> Delayed dental maturation <input type="checkbox"/> Constipation <input type="checkbox"/> Oligomenorrhea <input type="checkbox"/> Makroglossia <input type="checkbox"/> Mental retardation <input type="checkbox"/> Lethargy, fatigue
<input type="checkbox"/> Weight gain <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Delayed bone age	
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

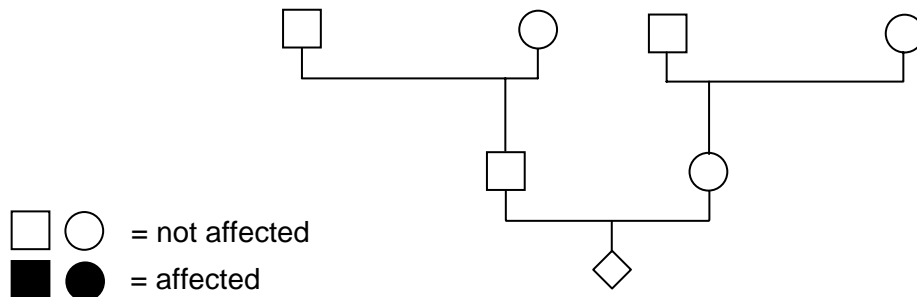
Pituitary size small normal enlarged

Thyroid size small normal enlarged

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 L-Thyroxine.

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 Pfäffle

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