Clinical Summary for New Health Care Team

BY THE ENDOCRINE SOCIETY

Form to be completed, signed, and dated on last page by referring provider and patient.
Patient and family to review and give completed form to new adult health care provider.
Please consider printing a copy for the patient.

Patient Name_____ **Date of Birth**_____

Date of Diagnosis_____ **Age of Diagnosis**_____

PRESENTING SYMPTOMS

_____

_____

_____

_____

ETIOLOGY OF GH DEFICIENCY:

- ☐ Isolated
- ☐ Mulitiple Pituitary Hormone Abnormalities
  - ☐ Thyroid
    - ☐ Deficiency
    - ☐ Excess
  - ☐ Adrenal
    - ☐ Hypercortsolism
    - ☐ Deficiency
  - ☐ Gonadotropins
    - ☐ Deficiency
    - ☐ Precocious Puberty
  - ☐ ADH
    - ☐ Diabetes Insipidus
    - ☐ SIADH
  - ☐ Cerebral Salt-Wasting
  - ☐ Prolactin
    - ☐ Excess
    - ☐ Deficiency
- ☐ Organic
- ☐ Congenital
- ☐ Chiari Malformation
- ☐ Genetic Testing
  - ☐ Mutation _____
  - ☐ No Genetic Testing
  - ☐ Optic Nerve Hypoplasia/ Septo-Optic Dysplasia
    - ☐ Holoprosencephaly
    - ☐ Other Midline Syndrome
  - Acquired: _____
- ☐ Mass Lesions
  - ☐ Craniopharyngioma
  - ☐ Rathke's Cleft Cyst
    - ☐ Other Brain Tumor: _____
  - ☐ Post-Surgical
  - ☐ Post-Radiation
  - ☐ Traumatic
  - ☐ Post-Hydrocephalus
  - ☐ Vascular Lesion
  - ☐ Pituitary Adenoma
  - ☐ Other: _____

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BASELINE LABORATORY TESTING (AT DIAGNOSIS)			
Growth Hormone Stimulation Test(s)			
Peak (units):		Stimulus:	Date:
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IGF-I: Stand. Dev. score:	Ref. Range:	Date:	
IGFBP-3Ref. Range:		Date:	
Prolactin Ref. Range:		Date:	
ACTH Ref. Range:		Date:	Time:
Cortisol Ref. Range:		Date:	Time:
Cortisol (Stimulation Test) — Cosyntropin (Cortrosyn) Dose: Baseline:	Ref. Range: Peak:	Date:	Start Time:
TSH Ref. Range:		Date:	
Free T4: Ref. Range:		Date:	
T4: Ref. Range:		Date:	
FSH:	Ref. Range:	Date:	
LH:	Ref. Range:	Date:	
Testosterone:	Ref. Range:	Date:	Time:
Free Testosterone:	Ref. Range:	Date:	Time:
Estradiol:	Ref. Range:	Date:	
Sodium:	Ref. Range:	Date:	
Other:	Ref. Range:	Date:	

PRIOR HORMONAL TREATMENT:		
Growth Hormone	Start Age:	Stop Age:
Was GH Status re-evaluated at conclusion of growth?	■ Yes	■ No
If so, how and what were the results?		

Patient Name_____ **Date of Birth**_____

CURRENT HORMONAL TREATMENT

Hormone Treatment	Formulation	Dose
☐ Growth Hormone		
☐ Thyroid Hormone		
☐ Glucocorticoids		
☐ Testosterone		
☐ Estrogen		
☐ Desmopressin (ddAVP)		
☐ Other		

OTHER PRIOR TREATMENT

Surgery	Date	Approach
1)		
2)		
3)		
Radiation Therapy	Dates:	Total Dose:
	Locations:	
Chemotherapy	Dates:	Agents:
Other: _____ _____	Dates: _____ _____	Type: _____ _____

MOST RECENT LABORATORY EVALUATIONS AND UNITS

Lab Evaluations	Units	Range	Date	On Treatment?
IGF-I				☐ Yes ☐ No
IGFBP-3				☐ Yes ☐ No
Free T4				☐ Yes ☐ No
T4				☐ Yes ☐ No
Testosterone				☐ Yes ☐ No
Free Testosterone				☐ Yes ☐ No

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MOST RECENT LABORATORY EVALUATIONS AND UNITS (CONTINUED)

Chemistry Panel		
Sodium	Date:	
Glucose	Date:	Fasting?: ☐ Yes ☐ No
Creatinine	Date:	
AST	Date:	
ALT	Date:	
HbA1c	Date:	
Lipids	☐ Yes ☐ No	
Total Cholesterol	Date:	
LDL Cholesterol	Date:	
HDL Cholesterol	Date:	
Triglycerides	Date:	
Other:	Date:	
Other	Date:	

MOST RECENT RADIOLOGY EVALUATIONS

Bone Age: Date:	Chronological Age:	
Head MRI Contrast: ☐ Yes ☐ No *Please attach full report, including CD of images, if possible*	Result:	Date:
DXA/QCT Scan Date:	Site:	Z Score:
Results: ☐ Cortical ☐ Cancellous	Site:	Z Score:
Please attach full report	Site:	Z Score:
Other	Result	Date:

Copy of patient's growth chart attached? ☐ Yes ☐ No

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OTHER EVALUATIONS		
Most Recent Data On:	**Results**	**Date**
Height		
Weight		
BMI		
Waist Circumference		
Waist-to-Hip Ratio		
Nurtrition		
Psychology/Psychiatry		
Sleep Disorders		
Other		

QUALITY OF LIFE MEASURES?_____

OTHER CONSULTANTS AND RESULTS: _____

_____

PRIMARY CARE PHYSICIAN: _____

EMAIL/PHONE:_____

Are there additional issues that you would like to discuss about this patient? ☐ Yes ☐ No

Would you like confirmation that this patient has established care with an adult provider? ☐ Yes ☐ No

If yes, please contact referring physician: _____

Phone Number: _____

Fax Number: _____

Email: _____

Notes _____

_____

Has this information been reviewed with the patient? ☐ Yes ☐ No

Has the first appointment been made? ☐ Yes ☐ No

Pediatric Providers: Please Attach A Clinical	Referring Physician Signature and Date

ENDOCRINE SOCIETY

IN COOPERATION WITH

ACP American College of Physicians

American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN™

Hormone Health Network Keep your body in balance

PES Pediatric Endocrine Society

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