

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
- Organic
- Multiple Pituitary Hormone Abnormalities
 - Thyroid
 - Deficiency
 - Excess
 - Adrenal
 - Hypercortisolism
 - Deficiency
 - Gonadotropins
 - Deficiency
 - Precocious Puberty
 - ADH
 - Diabetes Insipidus
 - SIADH
 - Cerebral Salt-Wasting
 - Prolactin
 - Excess
 - Deficiency
- 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-3	Ref. Range:	Date:
Prolactin	Ref. Range:	Date:
ACTH	Ref. Range:	Date: Time:
Cortisol	Ref. Range:	Date: Time:
Cortisol (Stimulation Test) – Cosyntropin (Cortrosyn) Dose:	Ref. Range:	Date: Start Time:
Baseline:	Peak:	
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, how and what were the results?		

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CURRENT HORMONAL TREATMENT		
Hormone Treatment	Formulation	Dose
<input type="checkbox"/> Growth Hormone		
<input type="checkbox"/> Thyroid Hormone		
<input type="checkbox"/> Glucocorticoids		
<input type="checkbox"/> Testosterone		
<input type="checkbox"/> Estrogen		
<input type="checkbox"/> Desmopressin (ddAVP)		
<input type="checkbox"/> 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				<input type="checkbox"/> Yes <input type="checkbox"/> No
IGFBP-3				<input type="checkbox"/> Yes <input type="checkbox"/> No
Free T4				<input type="checkbox"/> Yes <input type="checkbox"/> No
T4				<input type="checkbox"/> Yes <input type="checkbox"/> No
Testosterone				<input type="checkbox"/> Yes <input type="checkbox"/> No
Free Testosterone				<input type="checkbox"/> Yes <input type="checkbox"/> No

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MOST RECENT LABORATORY EVALUATIONS AND UNITS (CONTINUED)		
Chemistry Panel		
Sodium	Date:	
Glucose	Date:	Fasting?: <input type="checkbox"/> Yes <input type="checkbox"/> No
Creatinine	Date:	
AST	Date:	
ALT	Date:	
HbA1c	Date:	
Lipids	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Result: Date:
<i>Please attach full report, including CD of images, if possible</i>		
DXA/QCT Scan	Date:	Site: Z Score:
Results: Cortical	Cancellous	Site: Z Score:
<i>Please attach full report</i>		Site: Z Score:
Other	Result	Date:

Copy of patient's growth chart attached? Yes No

Patient Name _____ Date of Birth _____

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

IN COOPERATION WITH



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