NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.®

Name:

MRN:

DOB:

PATIENT IDENTIFICATION

NATIONWIDE CHILDREN'S HOSPITAL (NCH) PROVIDER REFERRAL FOR JOINT HYPERMOBILITY/CONCERN FOR EHLERS-DANLOS SYNDROME

Joint hypermobility (JH), by itself, often is a normal trait and, in our experience, most with JH do not need genetic testing. In situations where there is a personal or family history of any of the features noted in the table below, genetic testing may be considered.

An individual with JH may have additional features that would qualify them for a diagnosis of Hypermobile Ehlers-Danlos (most commonly chronic pain, joint dislocations, orthostatic intolerance, and family history of similar symptoms). This diagnosis can be made by history and physical examination and there is no genetic test available to help with this diagnosis.

Clinical Genetics is a service that provides consults on patients with rare conditions and makes recommendations for testing. Geneticists do not have special training in the management or treatment of chronic pain or biomechanical dysfunction. Rheumatology may be able to help more with management.

Family History:	Personal History
☐ Arterial aneurysms/dissection (or sudden cardiac death)	☐ Arterial aneurysms/dissection
☐ Hollow organ rupture	☐ Hollow organ rupture
☐ Pneumothorax	☐ Pneumothorax
☐ Uterine rupture during pregnancy	☐ Uterine rupture during pregnancy
☐ Known family history of Vascular EDS	☐ Unusual facial features for family
☐ Cleft palate or bifid uvula	☐ Cleft palate or bifid uvula
☐ lens dislocation	☐ Lens dislocation
☐ Prior Genetic Testing for Vascular EDS* *If Box is Checked Please Provide Copy of Result	☐ Paper-thin skin/poor wound healing (does not include keloid scarring)

Please check which box most closely matches your clinical suspicion:

High Suspicion of life-threatening vascular complications

☐ YES ☐ NO

If yes, please include a reason for your high clinical suspicion

_____

_____

Please explain: What is the specific question (s) you want addressed in this consultation?

_____

_____

_____ _____ _____

Referring Provider: _____

Name of Form Preparer: _____ Best Contact Number for Follow-up: _____

Please fax this form back to (614) 722 3546. We will evaluate the provided information and schedule if appropriate. If a genetics appointment is not indicated or no longer of interest, we will provide general recommendations for management of hypermobility.