GOODHOPE EHLERS-DANLOS SYNDROME (EDS) PROGRAM

REFERRAL PACKAGE

In order to request assessment for adults at the GoodHope EDS Program at Toronto General Hospital, please complete the form below and append the requested documentation.

Fax complete referral package to **416-340-3792**. Due to a very high volume of referrals, only patients for whom a complete referral package is received will be triaged to determine if they are suitable to be seen in the EDS Program. We encourage you to work with your patient to complete the referral package.

Please make special note of the **items marked with an ***, which are **required accompanying documentation**. Incomplete referral packages will not be triaged.

Referring physician information:

Name	
Specialty	
Physician billing number	
Mailing address	
Telephone	
Fax	
Email	

Patient information:

Name	
Date of birth (month/day/year)	
OHIP number	
Mailing address	
Telephone	

Name / DOB	

All referrals <u>require</u> an echocardiogram report in order to triage - If your patient does not have a 2D echocardiogram on file please order for your patient and send completed referral once echo results are available. Echo results should be from within the last 3 years.

<u>Reason for referral</u> My patient has a:

<u>Suspected</u> <u>diagnosis of EDS</u>

Please indicate what makes you and your patient suspicious of the diagnosis:

<u>Known</u> <u>diagnosis of EDS</u>

Please indicate why the patient is being referred to our program and their goals of the visit:

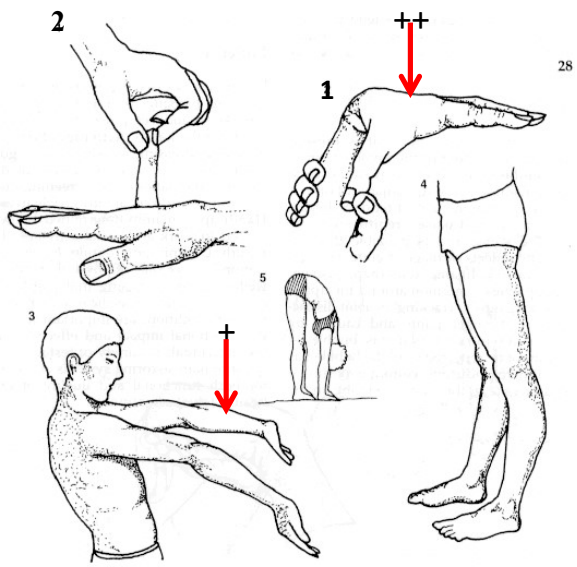
For **all patients**, please provide the following, if available:

- Consultation reports from any pertinent specialists
- For patients with a previous diagnosis: Detailed diagnostics notes +/- genetic testing results
- Recent laboratory tests, imaging (i.e.. MRI) or other pertinent investigations (i.e. EMG)

Name / DOB	

Please complete the Beighton score as indicated below (**required***):
Please refer to the weblink below for the technique of the Beighton testing.
[Assessing Joint Hypermobility with the Beighton Scale - YouTube]

	CLINICAL MANEUVER	UNABLE TO PERFORM (0 POINTS)	ABLE TO PERFORM (1 POINT)	
1	Apposition of thumb to forearm Right Left	 0 0	 1 1	
2	Extension of fifth finger beyond 90 degrees Right Left	 0 0	 1 1	
3	Extension of elbow beyond 10 degrees Right Left	 0 0	 1 1	
4	Extension of knee beyond 10 degrees Right Left	 0 0	 1 1	
5	Forward flexion of trunk, legs straight, palms touching floor	0	1	
	Total Beighton Score (sum of points for each maneuver)	0 to 9 points		/9



+ and ++ indication locations where skin hyperextensibility should be measured (see checklist on page 4)

Please indicate if any of the following apply:

- ☐ Previous Amputation - Specify:_____
- ☐ Previous Joint surgery - Specify: _____
  _____
  _____
- ☐ Wheelchair-bound

Name/ DOB	

Clinical checklist: Please indicate (√) if your patient has any of the following:

✓ if present	*Please send documentation if available		
	*Aneurysm or dissection of any vessel?	Which vessel(s)?	
	*Spontaneous organ rupture (i.e. colon, uterus, orbit)	Which organ(s)?	
	*Spontaneous pneumothorax?	Number of times? Age?	
	*Confirmed family history of EDS	**Type of EDS**? Relationship?	
	Skin hyperextensibility/abnormally stretchy skin	Pinch and lift the cutaneous skin layers at	
		Volar surface of forearm (+ on diagram)	_____ cm
		Dorsum of hand (++ on diagram)	_____ cm
	Atrophic scarring (not striae)	Specify sites:	
	*Recurrent abdominal hernias	Specify location and number of occurrences:	
	*Organ prolapse:	Nulliparous? Which organs?	
	Anxiety, depression or other psychiatric diagnosis?	Specify:	
	*Congenital malformation (i.e. club foot, congenital hip dislocation)	Specify:	

Name/ DOB	

Family physician or specialist who will provide ongoing care

*****Patient **must** have a primary care practitioner or specialist prepared to be an active participant in his/her care and provide follow-up. Please have this physician complete and sign the following (**required***).

To whom it may concern:

Your patient has been referred to the GoodHope Ehlers-Danlos Syndrome Program at University Health Network. One of our referral criteria is that the patient's referring clinician/primary care practitioner play an active role in the ongoing care of their patients. The referring clinician will be responsible for following up with recommendations for testing and management as suggested by our team.

If in agreement, please sign this form.

Referring Clinician

_____

Signature

_____

Print Name

_____

Fax number

_____

Date (mm/dd/yy)

Primary Care Practitioner information (if not referring clinician)

_____

Print Name

_____

Fax number