Centre universitaire de santé McGill
McGill University Health Centre

FMU-8689

REFERRAL FORM
CONNECTIVE TISSUE DISORDER

Thank you for referring your patient.

Isolated hypermobility is a common condition for which there is currently no role for genetic evaluation or genetic testing to confirm the diagnosis. We therefore are no longer accepting referrals for **isolated hypermobility**. You may wish to refer your patient to another medical specialist for management of symptoms, if required.

Additional information about hypermobility/Ehlers Danlos Type III can be found at:
https://www.ncbi.nlm.nih.gov/books/NBK1279/

However, for patients who display hypermobility and/or other connective tissue signs and symptoms, please complete this form. The information provided will help determine whether an evaluation in genetics is indicated. Please make special note of the items marked with an « * », which are required accompanying documentation. Incomplete referral forms will not be triaged.
All adolescent and adult patients should have had a screening echocardiogram within the last 3 years*.

Referring physician information

Name	
Specialty	
Mailing address	
Telephone	
Fax	
Email	

Reason for referral (please check all applicable factors)

- ☐ Aortic root enlargement or aneurysm / dissection
- ☐ Generalized arterial tortuosity or aneurysm
- ☐ Ectopia lentis (dislocated lens)
- ☐ Clubfoot deformity
- ☐ Severe scoliosis
- ☐ Pectus deformity
- ☐ Bifid uvula or cleft palate
- ☐ Joint dislocation (requiring visit to emergency room for reduction); which joints, amount of occurrences, activity at time of dislocation
- ☐ Beighton ccore* (see chart on the next page)

_____

- ☐ Skin fragility; abnormal stretch marks; hyperextensibility/abnormally stretchy skin
- ☐ Thin, translucent skin
- ☐ Easy bruising
- ☐ Atrophic scars; specify site(s)

_____

- ☐ Tissue fragility; e.g. hernias, recurrent rectal or uterine prolapse
- ☐ Intestinal/uterine fragility or rupture
- ☐ Pneumothorax, spontaneous
- ☐ Spontaneous organ rupture (specify) _____
- ☐ Anxiety, depression or other psychiatric diagnosis (specify)

_____

- ☐ A family member with a genetic mutation which causes a connective tissue disorder (include copy of result)
- ☐ Family history of sudden death at age of 40 years old or less
- ☐ Previous joint surgery (specify)

_____

- ☐ Previous amputation (specify)

_____

- ☐ Wheelchair-bound
- ☐ Other pertinent features in your patient

_____
_____
_____
_____
_____

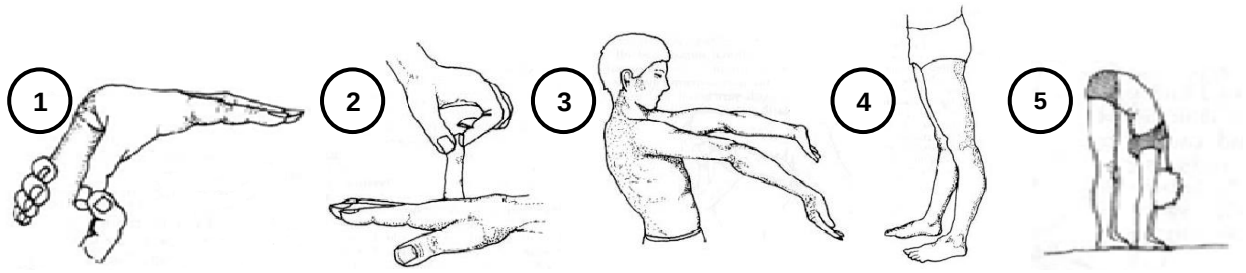
Division of Medical Genetic, 1001 boulevard Décarie, Bloc A4, room 3140 (Bloc A4.3140), Montréal, Qc, H4A 3J1
Email: genetics@muhc.mcgill.ca Tel:514-412-4427 Fax:514-412-4296

Please complete the **Beighton score** as indicated below **(required*).**
Please refer to the web link below for the technique of the Beighton Testing.

https://www.youtube.com/watch?v=uYRYsCW0gI8

	CLINICAL MANEUVER	UNABLE TO PERFORM (0 POINT)	ABLE TO PERFORM (1 POINT)
1	Appposition of thumb to forearm		
	Right	**0**	**1**
	Left	**0**	**1**
2	Extension of 5th finger beyond 90 degrees		
	Right	**0**	**1**
	Left	**0**	**1**
3	Extension of elbow beyond 10 degrees		
	Right	**0**	**1**
	Left	**0**	**1**
4	Extension of knee beyond 10 degrees		
	Right	**0**	**1**
	Left	**0**	**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)		

« **Beighton score positive;**
for child: **6 points** or more; from puberty to 50 years old: **5 points** or more; for 50 years old or more: **4 points** or more »



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

- **Copy of screening echocardiogram***
- Consultation reports from any pertinent specialists, recent laboratory tests and imaging (e.g. MRI)

We will provide assessment and management recommendations for your patient. In some cases, management and referrals may be initiated by our service.
However, after initial consultation, the patient will be returned to you for ongoing care.

We will proceed with triaging the referral upon receipt of a complete referral form.
Please fax the referral back to the Genetics Clinic at 514-412-4296 or email to *genetics@muhc.mcgill.ca*

_____ _____
Signature Date (YYYY/MM/DD)