Akron Children's

Provider Referral for Joint Hypermobility/ Concern for Ehlers-Danlos Syndrome

Name:
MRN:
DOB:
Patient Identification

Joint hypermobility (JH), in isolation, is often a common trait that does not indicate the need for genetic testing. These patients may still experience symptoms from JH. Patients may benefit from a referral to a physician who is knowledgeable regarding the symptoms and treatment for JH.

An individual with JH may have additional features that would qualify them for a diagnosis of Hypermobile Ehlers-Danlos Syndrome (most commonly chronic pain, joint dislocations, and family history of similar symptoms). A 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 consultations for 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, Pain Management and/or Physical Therapy may be better equipped to help with management of pain and joint instability. In situations where there is a personal or family history of any of the features noted in the table below, genetic evaluation may be considered.

Please check which box(es) most closely matches your clinical suspicion:

A referral for a genetic evaluation is indicated in patients with hypermobility (Beighton score >4) PLUS a personal or family history of the following:	**Personal History**	**Family History**
Aneurysm or dissection of aorta or arteries	☐	☐
Bowel or uterine rupture	☐	☐
Pelvic or rectal prolapse	☐	☐
Atraumatic, spontaneous pneumothorax	☐	☐
Ocular involvement: Retinal detachment, lens dislocation, corneal rupture, myopia > 7 diopters	☐	☐
Marfanoid body habitus	☐	☐
Bilateral hip dysplasia	☐	☐
Skin involvement: Thin, translucent skin, fragile skin (splits easily after minor trauma), widened atrophic scars	☐	☐
Concern for classic/vascular EDS	☐	☐
Abnormal genetic testing	☐	☐
Cleft palate or bifid uvula	☐	☐

*If Box is Checked Please Provide Copy of Results/Evaluation

High Suspicion of life-threatening vascular complications: ☐ Yes *or* ☐ No

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

_____

_____

Please explain: What is the specific question or questions that you want addressed in this consultation: _____

_____

_____

Referring Provider: _____

Name of Form Preparer: _____

Best Phone Number for Follow-up: _____

Please fax this form back to (330) 543-3677. We will evaluate the information provided 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.