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**Referral Form for Genetic Obesity Testing by NGS**

**East of Scotland Regional Genetics Laboratory, Level 6 Ninewells Hospital, Dundee DD1 9SY**

Lab enquiries: [Tay.esrg@nhs.scot](mailto:Tay.esrg@nhs.scot) (website: [www.esrg.scot.nhs.uk](file:///\\nwh-file-02.tnhs.tayside.scot.nhs.uk\departments$\Migration\shylock\Images\Mol_Genetics\Next%20Gen\Endocrine%20panel\Proforma\www.esrg.scot.nhs.uk))

*The indication for testing is BMI >3.5 SDS and age of onset <5 years. This test is not appropriate for individuals who also have global developmental delay and/or significant dysmorphic features. In these cases, a referral should be made to Clinical Genetics.*

*A local genetics consent form must also be supplied. NHS Tayside requests can be made via ICE.*

*Local contact name of obesity champion: …………………………………..…………………………………..*

**Patient Details (stickers can be used):**

|  |  |
| --- | --- |
| SURNAME: | PATIENT POSTCODE: |
| FORENAME | PEDIGREE/REFERENCE: |
| D.O.B. / CHI NUMBER: | GENDER AND ETHNIC ORIGIN: |

**Referring Clinician:**

|  |  |
| --- | --- |
| NAME: | SPECIALITY: |
| TELEPHONE: | EMAIL: |
| ADDRESS: | |

**Clinical Details:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age of onset ……………………     |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **At presentation**  **Date:** | Value | SDS |  | **Most recent**  **Date:** | Value | SDS | | Weight (kg) |  |  | Weight (kg) |  |  | | Height (cm) |  |  | Height (cm) |  |  | | BMI (kg/m2) |  |  | BMI (kg/m2) |  |  |     Hyperphagia  Yes  No Describe…………………………………………………………  Autism/Behavioural problems  Yes  No Describe…………………………………………………………  Hypogonadism  Yes  No Describe…………………………………………………………  Other medical conditions  Yes  No Describe…………………………………………………………  Consanguineous relationship  Yes  No Describe…………………………………………………………  Family history of obesity  Yes  No Describe…………………………………………………………  Abnormal biochemical results  Yes  No Describe…………………………………………………………  (glucose, liver function, lipids, thyroid)  Any features consistent with a specific syndrome? Please describe:  Family History. Please indicate if family members are known to be obese/severely obese: |

**Clinical Utility:**

Genetic test required to establish a diagnosis  Genetic test will be used for predictive testing

Genetic test will alter management  Genetic test will be used for prenatal diagnosis

Genetic test will predict prognosis/recurrence risk

**Urgent requests can be accommodated but these must be discussed in advance with the laboratory.**

Genes: *ALMS1, ARL6, BBS1, BBS10, BBS12, BBS2, BBS4, BBS5, BBS7, BBS9, CEP19, GNAS, LEP, LEPR, MC4R, MKKS, MKS1, MYT1L, NTRK2, PCSK1, PHF6, POMC, SDCCAG8, SIM1, TTC8, VPS13B*