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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 (website: [www.esrg.scot.nhs.uk](file:///%5C%5Cnwh-file-02.tnhs.tayside.scot.nhs.uk%5Cdepartments%24%5CMigration%5Cshylock%5CImages%5CMol_Genetics%5CNext%20Gen%5CEndocrine%20panel%5CProforma%5Cwww.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*