CLINICAL SUMMARY AND TRANSFER RECORD

FOR YOUTH WITH TURNER SYNDROME

BY THE ENDOCRINE SOCIETY

ENDOCRINETRANSITIONS.ORG

Name: _____ Date of Birth:____ /____ /_____

Diagnosis:

☐ Prenatal: If yes, was test obtained because of concern for Turner Syndrome? ☐ No ☐ Yes

OR

☐ Postnatal: If yes, age at diagnosis _____

Karyotype: _____

Probe for 'Y' chromosome ☐ No ☐ Yes: Results_____ Method: ☐ FISH ☐ Other

PROBLEM LIST:

Problem	Date Dx

HORMONE REPLACEMENT

Name	Dose	Route	Frequency	Indication
Estrogen • Ethinyl estradiol • Estradiol • Micronized progesterone		• Transdermal • Intramuscular • Oral		
Progestin • Medroxyprogesterone • Micronized progesterone		• Oral		
Oral Contraceptive Name: _____		• Oral • Transdermal		

OTHER MEDICATIONS:

Name	Dose	Route	Frequency	Indication

Name: _____ Date of Birth:____ /____ /_____

CARDIOVASCULAR HEALTH

	No	Yes	
Heart Disease	☐	☐	☐ Bicuspid valve ☐ Coarctation ☐ Aortic dilatation ☐ Other:
Electrocardiogram	☐	☐	☐ attached Date: Findings:
Cardiac Echo	☐	☐	☐ attached Date: Findings:
Cardiac MRI/A	☐	☐	☐ attached Date: Findings:
Lipid Abnormalities	☐	☐	**Date of Dx: Abnormality:**
If yes - Diet changes?	☐	☐	Date started: Describe
If yes - On medication?	☐	☐	Date started:
Hypertension	☐	☐	**Date of Dx: BP at that time: /**
If yes - On medication?	☐	☐	Date started:
Diabetes (probable type 2)	☐	☐	OGTT: Date: Fasting glucose 2 hr glucose
If yes - Diet changes?	☐	☐	Date started: Describe:
If yes - On medication?	☐	☐	Date started:
Overweight or Obese	☐	☐	**BMI:**
Other Cardiovascular Risk Factors	☐	☐	
Family History of early MI*	☐	☐	Relation: Age at MI:
Family history of clotting*	☐	☐	Relation: Age at MI:
Patient smokes	☐	☐	
Second hand smoke exposure	☐	☐	
Sedentary activities	☐	☐	

REPRODUCTIVE/WOMEN'S HEALTH

	No	Yes	
Puberty	☐	☐	
Spontaneous breast development	☐	☐	
Spontaneous menarche	☐	☐	Date of Menarche:
Evidence of primary ovarian failure	☐	☐	Date: LH: FSH:
Estrogen replacement	☐	☐	Year started:
Progesterone replacement	☐	☐	Year started:
Full hormonal dosing achieved	☐	☐	Year:
Reproductive endocrinology	☐	☐	
Have you seen a reproductive endocrinologist?	☐	☐	Name:
Summary:	☐	☐	
Have you undergone any reproductive technologies	☐	☐	☐ Oocyte cryopreservation ☐ Ovarian tissue cryopreservation ☐ Embryo cryopreservation ☐ Other
Bone Health	☐	☐	
Osteoporosis – symptomatic with fractures	☐	☐	
Osteoporosis – treated with medication	☐	☐	Dates: Medication:
Vitamin D deficiency	☐	☐	Treatment:
DEXA	☐	☐	☐ attached Date: Findings:
Family history of osteoporosis*	☐	☐	
High risk race: Caucasian/Asian	☐	☐	
Poor calcium intake	☐	☐	

Name: _____ Date of Birth:____ /____ /_____

GROWTH PROMOTING THERAPY

	No	Yes		
Growth hormone therapy	☐	☐	Date started:	Date stopped:
Oxandrolone therapy	☐	☐	Date started:	Date stopped:
Other medication	☐	☐	Date started:	Date stopped:

AUDIOLOGY

	No	Yes	
Audiology Evaluation	☐	☐	Date:
Hearing Impairment	☐	☐	Findings:
Hearing Aid	☐	☐	☐ Right only ☐ Left only ☐ Both

RENAL

	No	Yes	
Renal US	☐	☐	☐ attached Date: Findings:
Hx of Urinary Tract Infections	☐	☐	Date of most recent:
Hx of Urologic Surgery	☐	☐	Date: Procedure:

AUTOIMMUNE DISEASE

	No	Yes	
Chronic lymphocytic thyroiditis	☐	☐	Dx date:
On thyroxine replacement	☐	☐	Date started:
Hyperthyroidism	☐	☐	Dx date:
Anti-thyroid medication	☐	☐	Date started: Date stopped: Complications:
Thyroidectomy	☐	☐	Date:
Radioactive iodine	☐	☐	Dose(s):
Celiac Disease	☐	☐	Dx Date:
Type 1 diabetes	☐	☐	Dx Date:
Other	☐	☐	

LEARNING/BEHAVIOR ISSUES

	No	Yes	
Academics	☐	☐	
Currently in School	☐	☐	Current grade/school:
Neuropsych testing:	☐	☐	Summary:
Behavior and Mental Health	☐	☐	
ADD or ADHD	☐	☐	Date of diagnosis: Date medication started:
Depression	☐	☐	Date of diagnosis: Date medication started:
Anxiety or OCD	☐	☐	Date of diagnosis: Date medication started:
Social challenges	☐	☐	☐ Social isolation ☐ Immaturity ☐ Other:
Family history of…	☐	☐	
Mental health disorders*	☐	☐	
Alcohol or substance abuse*	☐	☐	

*If family history not known, write N/A.

Name: _____ Date of Birth:____ /____ /_____

RECENT PHYSICAL EXAM FINDINGS

Date: _____

Height	
Weight	
BMI	
Waist/Hip ratio	
Blood pressure	
Lymphedema	Location:
Curvature of the spine	

RECENT LABORATORY STUDIES

Test Name	Date	Result
Non-HDL cholesterol		
LDL cholesterol		
Triglycerides		
Fasting glucose		
2 hour stimulated glucose		
HgbA1c		
Anti-mullerian hormone		
25, OH Vitamin D		
1,25 OH Vitamin D		
Free T4		
TSH		
Thyroid antibodies		
Thyroid stimulating immunoglobulins		
Transglutaminase Antibodies		
Endomysial Antibodies		
HLA DQ testing		
Quantitative IgA		
ALT		
AST		
Urinalysis		
CBC		
Other		

HOSPITALIZATIONS/SURGERIES:

Date	Reason

Name: _____ Date of Birth:____ /____ /_____

PHYSICIAN CARE TEAM (PREVIOUS AND CURRENT)

	N/A	Pediatric Providers Name/Address/Phone/Fax	Receiving Adult Providers Name/Address/Phone/Fax
Primary Care			
Endocrinologist			
Cardiologist			
Nephrologist			
Dentist			
Orthodontist			
Ophthalmologist			
Ear Nose and Throat			
Orthopedist			
Reproductive Endocrinologist			
Mental Health Provider Social worker/Psychologist/ Psychiatrist			
Other			

ENDOCRINE SOCIETY