

## GOODHOPE EHLERS-DANLOS SYNDROME (EDS) PROGRAM

### REFERRAL PACKAGE

In order to request assessment for adults at the GoodHope EDS Program at Toronto General Hospital, please complete the form below and append the requested documentation.

**Fax complete referral package to 416-340-3792.** Due to a very high volume of referrals, only patients for whom a complete referral package is received will be triaged to determine if they are suitable to be seen in the EDS Program. We encourage you to work with your patient to complete the referral package.

Please make special note of the **items marked with an \***, which are **required accompanying documentation**. Incomplete referral packages will not be triaged.

**Referring physician information:**

Name	
Specialty	
Billing number	
Are you the active primary care provider?	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>Please note we only accept patients with an active primary care provider (see last page)</small>
Mailing address	
Telephone	
Fax	
Email	

**Patient information:**

Name	
Date of birth (month/day/year)	
OHIP number	
Mailing address	
Telephone	

Name / DOB	
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**\*All referrals require an echocardiogram report in order to triage\*** - If your patient does not have a 2D echocardiogram on file please order for your patient and send completed referral once echo results are available. Echo results should be from within the last 3 years.

**Reason for referral**

**Suspected** diagnosis of EDS

Please indicate what makes you and your patient suspicious of the diagnosis:

**Known** diagnosis of EDS

Please indicate why the patient is being referred to our program and their goals of the visit:

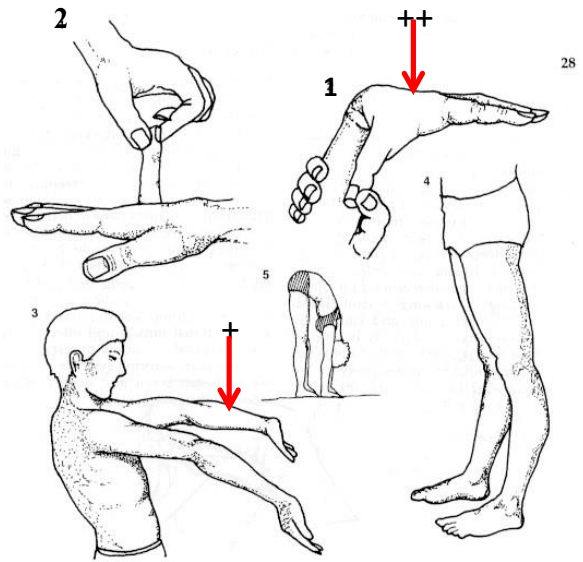
For **all patients**, please provide the following, if available:

- Consultation reports from any pertinent specialists
- For patients with a previous diagnosis: Detailed diagnostics notes +/- genetic testing results
- Recent laboratory tests, imaging (i.e.. MRI) or other pertinent investigations (i.e. EMG)

Name / DOB	
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Please complete the Beighton score as indicated below (**required\***):  
Please refer to the weblink below for the technique of the Beighton testing.  
[Assessing Joint Hypermobility with the Beighton Scale - YouTube](#)

	CLINICAL MANEUVER	UNABLE TO PERFORM (0 POINTS)	ABLE TO PERFORM (1 POINT)
1	Apposition of thumb to forearm		
	Right	0	1
	Left	0	1
2	Extension of fifth 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
<b>Total Beighton Score</b> (sum of points for each maneuver)		0 to 9 points	<b>/9</b>



**Beighton score must be assessed by the referring provider/specialist. We are unable to accept patient self-reported Beighton score.**

+ and ++ indication locations where measured (see checklist on page 4)

Please indicate if any of the following apply:

- Previous Amputation - Specify: \_\_\_\_\_
- Previous Joint surgery - Specify: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- Wheelchair-bound

Name/ DOB	
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**Clinical checklist:** Please indicate (✓) if your patient has any of the following:

✓ if present	<b>** Please send documentation if available</b>	
	<b>**Aneurysm or dissection of any vessel?</b>	Which vessel(s)?
	<b>**Spontaneous organ rupture (i.e. colon, uterus, orbit)</b>	Which organ(s)?
	<b>**Spontaneous pneumothorax?</b>	Number of times? Age?
	<b>**Confirmed family history of EDS</b>	<b>Type of EDS?</b>  Relationship?
	Skin hyperextensibility/abnormally stretchy skin	Pinch and lift the cutaneous skin layers at
		Volar surface of forearm (+ on diagram) _____ cm
		Dorsum of hand (++ on diagram) _____ cm
	Atrophic scarring (Not striae)	Specify sites:
	<b>**Recurrent abdominal hernias</b>	Specify location and number of occurrences:
	<b>**Organ prolapse:</b>	Was prolapse Nulliparous? Which organs prolapsed?
	Anxiety, depression or other psychiatric diagnosis?	Specify:
	<b>**Congenital malformation (i.e. club foot, congenital hip dislocation)</b>	Specify:

Name/ DOB	
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**Required: Primary care provider who will provide ongoing care**

\*Patient **MUST** have an active primary care practitioner in order to be assessed at the GoodHope EDS program. We are unable to see patients without an active primary care provider. Referrals without active primary care provider will be declined.

\*\* All patients will have EDS diagnosis assessed and confirmed/ruled out by the GoodHope EDS program. Only patients who diagnoses can be confirmed/verified by the GoodHope EDS program will be eligible to receive services within the program.

**Referring clinician**

By signing this referral form, you confirm that you are actively following this patient and agree to work with the patient and the GoodHope EDS team to consider the recommendations for care provided by the GoodHope EDS program.

**Referring Clinician:**

- Primary care provider
- Specialist

Primary Care Practitioner information (if not referring clinician)

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
 Fax number

\_\_\_\_\_  
**Fax number**

Patient does not have an active primary care provider

\_\_\_\_\_  
**Date (mm/dd/yy)**