

**ΕΝΤΥΠΟ ΠΑΡΑΠΟΜΠΗΣ ΓΙΑ ΑΛΛΗΛΟΥΧΙΣΗ ΕΠΟΜΕΝΗΣ ΓΕΝΙΑΣ (NGS)
ΟΛΩΝ ΤΩΝ ΕΞΟΝΙΩΝ ΤΟΥ ΓΟΝΙΔΙΩΜΑΤΟΣ (Whole Exome Sequencing, WES)**

ΗΜΕΡΟΜΗΝΙΑ ΛΗΨΗΣ ΔΕΙΓΜΑΤΟΣ:.....

ΗΜΕΡΟΜΗΝΙΑ ΠΑΡΑΛΑΒΗΣ ΔΕΙΓΜΑΤΟΣ:.....

ΚΩΔΙΚΟΣ ΔΕΙΓΜΑΤΟΣ:

ΕΙΔΟΣ ΔΕΙΓΜΑΤΟΣ: Περιφερικό αίμα Άλλο

ΣΤΟΙΧΕΙΑ ΠΑΡΑΠΕΜΠΟΝΤΟΣ ΙΑΤΡΟΥ

Όνοματεπώνυμο:

Τηλ:email:.....

ΣΤΟΙΧΕΙΑ ΕΞΕΤΑΖΟΜΕΝΟΥ/ΗΣ:

Όνοματεπώνυμο:.....Ηλικία:.....

Διεύθυνση:.....Πόλη:.....ΤΚ:.....

Τηλέφωνα επικοινωνίας:.....

email:.....

ΕΙΔΟΣ ΕΞΕΤΑΣΗΣ

Αλληλούχιση Επόμενης Γενιάς όλων των εξονίων του γονιδιώματος (WES) και ερμηνεία αποτελεσμάτων
Whole Exome Sequencing and Interpretation
ΚΛΗΡΟΝΟΜΙΚΑ ΝΟΣΗΜΑΤΑ

ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ

Οικογενειακό Ιστορικό:

Αιτία Παραπομπής:.....

Προηγούμενος γενετικός έλεγχος:.....

Απεικονιστικός έλεγχος (ΗΚΓ, ΗΕΓ, MRI):

Βιοψία:.....

Άλλος Εργαστηριακός έλεγχος (Αιματολογικός, βιοχημικός, μεταβολικός

κ.α):.....

Φαρμακευτική αγωγή:.....

Σημειώσεις:.....

Κλινικά στοιχεία ασθενούς:

Παρακαλώ όπως συμπληρώσετε τις παρακάτω κλινικές πληροφορίες για τον/την ασθενή, βασιζόμενες στη βάση δεδομένων Human Phenotype Ontology - HPO.

Η λεπτομερής καταγραφή των κλινικών πληροφοριών αυξάνει την πιθανότητα ανίχνευσης της γενετικής αιτίας του φαινοτύπου του/της ασθενούς κατά την ανάλυση των δεδομένων από την εξέταση αλληλούχησης επόμενης γενιάς.

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| <p><u>Prenatal medical history:</u></p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Prematurity</p> <p><input type="checkbox"/> Intrauterine growth restriction (IUGR)</p> <p><input type="checkbox"/> Poly- / Oligohydramnios</p> <p><input type="checkbox"/> Decreased fetal movement</p> <p><input type="checkbox"/> Other:.....</p> | <p><u>Developmental disorders</u></p> <p><input type="checkbox"/> Intellectual disability (<input type="checkbox"/> mild, <input type="checkbox"/> moderate, <input type="checkbox"/> severe)</p> <p><input type="checkbox"/> Global developmental delay (<input type="checkbox"/> mild, <input type="checkbox"/> moderate, <input type="checkbox"/> severe)</p> <p><input type="checkbox"/> Delayed motor milestones</p> <p><input type="checkbox"/> Delayed speech / language development</p> <p><input type="checkbox"/> Learning difficulties</p> <p><input type="checkbox"/> Autism spectrum disorder</p> <p><input type="checkbox"/> Developmental regression</p> <p><input type="checkbox"/> Other:.....</p> <p><input type="checkbox"/> No intellectual disability</p> <p><input type="checkbox"/> No developmental disorder</p> <p><input type="checkbox"/> Not examined / unknown</p> | <p><u>Craniofacial anomalies</u></p> <p><input type="checkbox"/> Macrocephaly</p> <p><input type="checkbox"/> Microcephaly</p> <p><input type="checkbox"/> Craniosynostosis</p> <p><input type="checkbox"/> Broad forehead</p> <p><input type="checkbox"/> Cleft lip palate</p> <p><input type="checkbox"/> Hypertelorism</p> <p><input type="checkbox"/> Hypotelorism</p> <p><input type="checkbox"/> Abnormality of the nose (Please specify.....)</p> <p><input type="checkbox"/> Abnormal ears (Please specify.....)</p> <p><input type="checkbox"/> Micrognathia</p> <p><input type="checkbox"/> Oligodontia</p> <p><input type="checkbox"/> Other:.....</p> <p><input type="checkbox"/> No craniofacial anomalies</p> <p><input type="checkbox"/> Not examined / unknown</p> |
| <p><u>Respiratory symptoms</u></p> <p><input type="checkbox"/> Respiratory insufficiency</p> <p><input type="checkbox"/> Respiratory failure</p> <p><input type="checkbox"/> Apnea</p> <p><input type="checkbox"/> Recurrent infections</p> <p><input type="checkbox"/> Bronchiectasis</p> <p><input type="checkbox"/> Pneumothorax</p> <p><input type="checkbox"/> Other:.....</p> <p><input type="checkbox"/> No respiratory symptoms</p> <p><input type="checkbox"/> Not examined / unknown</p> | <p><u>Neurological symptoms</u></p> <p><input type="checkbox"/> Seizures (<input type="checkbox"/> generalized/<input type="checkbox"/> focal <input type="checkbox"/> febrile / <input type="checkbox"/> other)</p> <p><input type="checkbox"/> Encephalopathy</p> <p><input type="checkbox"/> Abnormal nerve conduction velocity</p> <p><input type="checkbox"/> Neuropathy (<input type="checkbox"/> motor/<input type="checkbox"/> sensory)</p> <p><input type="checkbox"/> Ataxia</p> <p><input type="checkbox"/> Tremor</p> <p><input type="checkbox"/> Dystonia</p> <p><input type="checkbox"/> Chorea</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Gait disturbances</p> <p><input type="checkbox"/> Nystagmus</p> <p><input type="checkbox"/> Mood disturbances (<input type="checkbox"/> anxiety, <input type="checkbox"/> depression, <input type="checkbox"/> psychosis)</p> <p><input type="checkbox"/> Migraine, <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Sleep disturbances</p> <p><input type="checkbox"/> Unexplained pain</p> | <p><u>Neuromuscular symptoms</u></p> <p><input type="checkbox"/> Ataxia</p> <p><input type="checkbox"/> Chorea</p> <p><input type="checkbox"/> Dystonia</p> <p><input type="checkbox"/> Hypotonia (<input type="checkbox"/> generalized, <input type="checkbox"/> central, <input type="checkbox"/> muscular)</p> <p><input type="checkbox"/> Hypertonia</p> <p><input type="checkbox"/> Muscle weakness</p> <p><input type="checkbox"/> Muscular dystrophy</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Myotonia</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Elevated creatine kinase (Please specify.....)</p> <p><input type="checkbox"/> Ptosis</p> <p><input type="checkbox"/> Other:.....</p> <p><input type="checkbox"/> No neuromuscular symptoms</p> <p><input type="checkbox"/> Not examined / unknown</p> |

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| | <input type="checkbox"/> Other: <input type="checkbox"/> No neurological symptoms <input type="checkbox"/> Not examined / unknown | |
| <p><u>Skeletal symptoms</u></p> <input type="checkbox"/> Flexion contracture <input type="checkbox"/> Arthrogyposis (congenital? <input type="checkbox"/> yes/ <input type="checkbox"/> no) <input type="checkbox"/> Short stature (skeletal dysplasia? <input type="checkbox"/> yes/ <input type="checkbox"/> no) <input type="checkbox"/> Tall stature (overgrowth? <input type="checkbox"/> yes/ <input type="checkbox"/> no) <input type="checkbox"/> Joint Hypermobility <input type="checkbox"/> Hand- / <input type="checkbox"/> Foot polydactyly (bilateral? <input type="checkbox"/> yes / <input type="checkbox"/> no) <input type="checkbox"/> Hand- / <input type="checkbox"/> Foot syndactyly (bilateral? <input type="checkbox"/> yes / <input type="checkbox"/> no) <input type="checkbox"/> Camptodactyly of finger <input type="checkbox"/> Clubfoot (congenital? <input type="checkbox"/> yes/ <input type="checkbox"/> no) <input type="checkbox"/> Scoliosis <input type="checkbox"/> Kyphosis <input type="checkbox"/> Pectus excavatum <input type="checkbox"/> Pectus carinatum <input type="checkbox"/> Abnormality of bone density (<input type="checkbox"/> increased/ <input type="checkbox"/> decreased) <input type="checkbox"/> Exostosis <input type="checkbox"/> Fractures <input type="checkbox"/> Delayed bone age <input type="checkbox"/> Other: | <p><u>Hearing defects</u></p> <input type="checkbox"/> Sensorineural hearing impairment (bilateral? <input type="checkbox"/> yes / <input type="checkbox"/> no) <input type="checkbox"/> Conductive hearing impairment (bilateral? <input type="checkbox"/> yes / <input type="checkbox"/> no) <input type="checkbox"/> Other: <input type="checkbox"/> No hearing defects <input type="checkbox"/> No vestibular abnormalities <input type="checkbox"/> Not examined / unknown | <p><u>Eye defects</u></p> <input type="checkbox"/> Visual impairment (bilateral? <input type="checkbox"/> yes/ <input type="checkbox"/> no) (Please specify)..... <input type="checkbox"/> Anophthalmia/ <input type="checkbox"/> Microphthalmia (bilateral? <input type="checkbox"/> yes / <input type="checkbox"/> no) <input type="checkbox"/> Strabismus (bilateral? <input type="checkbox"/> yes/ <input type="checkbox"/> no) <input type="checkbox"/> Coloboma <input type="checkbox"/> Congenital bilateral cataract <input type="checkbox"/> Blue sclera <input type="checkbox"/> Optic atrophy <input type="checkbox"/> Blindness <input type="checkbox"/> Retinitis pigmentosa <input type="checkbox"/> Other: <input type="checkbox"/> No eye defects <input type="checkbox"/> Not examined / unknown |
| <p><u>Metabolic and endocrine defects</u></p> <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Obesity <input type="checkbox"/> Suspected mitochondriopathy <input type="checkbox"/> Lactic acidosis <input type="checkbox"/> Proteinuria <input type="checkbox"/> Hyperglycemia <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Ketosis <input type="checkbox"/> Hypercalcemia <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Diabetes insipidus <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hypoparathyroidism <input type="checkbox"/> Exocrine pancreatic insufficiency <input type="checkbox"/> Other: <input type="checkbox"/> No metabolic abnormalities | <p><u>Cardiovascular defects</u></p> <input type="checkbox"/> Atrial septal defect <input type="checkbox"/> Ventricular septal defect <input type="checkbox"/> Abnormality of cardiac ventricle <input type="checkbox"/> Tetralogy of Fallot <input type="checkbox"/> Inherited Cardiomyopathies <input type="checkbox"/> Hypertrophic Cardiomyopathies <input type="checkbox"/> Arrhythmogenic Cardiomyopathies <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Abnormality of vasculature (Please specify.....) <input type="checkbox"/> Pulmonary arterial hypertension <input type="checkbox"/> Hypertension <input type="checkbox"/> Pulmonary arterial stenosis <input type="checkbox"/> Valve abnormalities | <p><u>Immunological and hematological abnormalities</u></p> <input type="checkbox"/> Autoinflammatory disease <input type="checkbox"/> Immunodeficiency (Please specify.....) <input type="checkbox"/> Recurrent infections <input type="checkbox"/> Anemia (Erythrocytes) <input type="checkbox"/> Neutropenia <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Abnormal coagulation <input type="checkbox"/> Megaloblastic anemia <input type="checkbox"/> Bone marrow failure <input type="checkbox"/> Leukemia (Please specify.....) <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Other: <input type="checkbox"/> No immunological abnormalities <input type="checkbox"/> No hematological abnormalities |

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| <input type="checkbox"/> No endocrine abnormalities <input type="checkbox"/> Not examined / unknown <input type="checkbox"/> Copy of laboratory findings attached | <input type="checkbox"/> Other: | <input type="checkbox"/> Not examined / unknown |
| <p><u>Skin, nails and hair</u></p> <input type="checkbox"/> Abnormality of connective tissue (Please specify.....) <input type="checkbox"/> Skin lesions (Please specify.....) <input type="checkbox"/> Multiple cafe-au-lait spots (Number.....) <input type="checkbox"/> Port-wine stain <input type="checkbox"/> Albinism <input type="checkbox"/> Progeroid appearance <input type="checkbox"/> Eczema <input type="checkbox"/> Edema <input type="checkbox"/> Ichthyosis <input type="checkbox"/> Dysplastic nails <input type="checkbox"/> Anhidrosis <input type="checkbox"/> Hyperhidrosis <input type="checkbox"/> Alopecia <input type="checkbox"/> Hypertrichosis (Where?.....) <input type="checkbox"/> Other: <input type="checkbox"/> No abnormalities of skin, nails and hair Not examined / unknown | <p><u>Renal and genitourinary tract abnormalities</u></p> <input type="checkbox"/> Renal cysts <input type="checkbox"/> Renal agenesis <input type="checkbox"/> Horseshoe kidney <input type="checkbox"/> Hypercalciuria <input type="checkbox"/> Hematuria <input type="checkbox"/> Proteinuria <input type="checkbox"/> Hypospadias <input type="checkbox"/> Hydronephrosis <input type="checkbox"/> Hypogonadism <input type="checkbox"/> Cryptorchidism <input type="checkbox"/> Ambiguous genitalia <input type="checkbox"/> Other: <input type="checkbox"/> No renal abnormalities <input type="checkbox"/> No genitourinary abnormalities Not examined / unknown | <p><u>Hepatic dysfunction</u></p> <input type="checkbox"/> Liver dysfunction (Please specify.....) <input type="checkbox"/> Recurrent acute liver failure <input type="checkbox"/> Hepatic cysts <input type="checkbox"/> Cholestasis <input type="checkbox"/> Hypercholanemia <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Other: <input type="checkbox"/> No hepatic abnormalities Not examined / unknown <p><u>Other</u></p> <input type="checkbox"/> Organomegaly (which?.....) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Episodic fever <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Hypothermia <input type="checkbox"/> Constipation, <input type="checkbox"/> Obstipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Episodic vomiting <input type="checkbox"/> Other: |