**FORM FOR REFERRING HYPERMOBILITY CASES FOR GENETICS ASSESSMENT**

**Please indicate type of referral: Routine referral**

**Referring clinician:**

Sign: Print name:

Title: Hospital:

Contact number: Email address:

Date:

**Patient details:**

Full name:

Date of birth:

Telephone no:

Address:

NHS number:

Hospital number:

GP name, address and telephone no:

**Oxford Genetics Department referral criteria for hypermobility assessment and suspected Ehlers Danlos Syndrome (EDS) cases**

Please consider referring patients with joint hypermobility and FH of hypermobility **ONLY** if they have any of the additional **RED FLAGS** listed below.

1. Extensive widened atrophic scars
2. Significant sagging skin
3. Premature aged appearance
4. Significant kyphoscoliosis
5. History of organ rupture
6. Young onset unexplained arterial dissection (Please state age of onset\_\_\_\_\_\_\_\_\_)
7. Hand and foot deformities
8. Young age unexplained significant or extensive varicosities (Please state age of onset\_\_\_\_\_\_)
9. Recurrent large hernias
10. Recurrent pneumothoraces

**Genetic testing *may* be offered to individuals if they are clinically suspected to have the rarer types of EDS via the nationally funded service at Sheffield or Northwick Park**