Pediatric to Adult Care Transitions Tools

Clinical Summary & Transfer Record for *Young Adults with Turner Syndrome*

Name: _____ DOB:___/___/_____

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 estradiol		○ Transdermal ○ Intramuscular ○ Oral		
Progestin ○ Medroxyprogesterone ○ Micronized progesterone		○ Oral		
Oral contraceptive Name_____		○ Oral ○ Transdermal		

Other Medications:

Name	Dose	Route	Frequency	Indication

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:**

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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			

Growth Promoting Therapy

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

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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 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.

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

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			