

EuroDSD WP05-2 Patient Endocrine Info Sheet

Please complete a form for each individual/ family member, and enclose with sample, and email to w.arlt@bham.ac.uk and d.m.holmes@bham.ac.uk

Patient ID Code _____ Clinical Centre _____

Country of Origin _____

Referred by Name: _____

Address:

Email: _____

Phone: _____

Karyotype 46,XX 46,XY Unknown/Other _____
 (Please specify)

Endocrine Assessment at the time of diagnosis:

	Value	Unit	Local Reference Range
Serum Cortisol (baseline)	_____	_____	_____
Serum Cortisol (after ACTH)*	_____	_____	_____
Serum 17-hydroxyprogesterone	_____	_____	_____
Serum 17-hydroxyprogesterone (30/60 min after 250 µg ACTH)	_____	_____	_____
Serum Androstenedione	_____	_____	_____
Serum Testosterone (baseline)	_____	_____	_____
Serum Testosterone (after HCG) **	_____	_____	_____
Serum DHEA (S)	_____	_____	_____
Plasma ACTH	_____	_____	_____
Plasma Renin Activity	_____	_____	_____
Serum Sodium	_____	_____	_____
Serum Potassium	_____	_____	_____
Other _____ (Please Specify)	_____	_____	_____

Test Conditions.

*ACTH test:

Dose:
Time points of sampling:

**HCG test:

Dose:
Time points of sampling:

Current medications:

EuroDSD WP05-2 Sample Info Sheet

Please complete a form for each individual/ family member, and enclose with sample.

Patient ID Code _____ Clinical Centre _____

Country of Origin _____

Referred by Name: _____

Address:

Email: _____

Phone: _____

These Samples Are From (Please tick appropriate box)

Index Patient Father Mother Sibling Other _____
(Please Specify)

Age at time of sample collection: ____ (years) ____ (months) *if neonatal*: ____ (days)

Section A—Urine Samples

Please send a 10-ml urine aliquot for analysis of urinary steroid metabolite excretion by gas chromatography/mass spectrometry (GC/MS). Urine aliquots should be stored at -20°C until shipment on dry ice. We can also extract urine from nappies/diapers. Please look at WP05-3 for instruction and collection sheet.

Was the patient on Glucocorticoid replacement during 24 hr collection period? Yes No

Collection Period 24-h Spot Urine Other _____ hrs
(Please Specify)

Date of Collection _____ **Total Volume of Collection (ml)** _____
Mandatory Field

Please send urine samples by courier to the address below, urine aliquots should be sent on dry ice, frozen nappies do not require dry ice but should be transferred from the freezer into a Styrofoam box. All samples should be sent by courier overnight express. Please email tracking number to w.arlt@bham.ac.uk and d.m.holmes@bham.ac.uk.

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E-mail: w.arlt@bham.ac.uk

Section B—Plasma/Serum Samples

Plasma Serum

Please send plasma or serum samples by courier to the address below; and, email notification of courier service and tracking number to friepe@pediatrics.uni-kiel.de on the day of shipment.

PD Dr. med. Felix Riepe
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Klinik für Allgemeine Pädiatrie
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24105 Kiel
Germany
Tel +49-431-597-1797 or 1690
Fax +49-431-597-1831
Email friepe@pediatrics.uni-kiel.de