Guy's and St Thomas' NHS Foundation Trust

Klinefelter Syndrome Young Persons Clinic Referral checklist

Name: _____ **Referred by:** _____

Date of Birth: _____ **GP address:** _____

NHS Number: _____ _____

Checklist:- *to be completed before referring the patient to clinic*

- ☐ **Main referral concern (note patients must be 16-21)**

If available:

- ☐ **Fasting Early Morning Hormones:** *including*
  - ☐ Testosterone
  - ☐ FSH
  - ☐ LH
  - ☐ Oestradiol
  - ☐ Prolactin
- ☐ Does the patient need an interpreter?
  - Which language_____

Please make sure the patient attends the clinic with:

- ☐ **A copy of their Genetics report**
- ☐ **A list of medication if on any drug therapy**
- ☐ **Copies of any formal psychological assessments (cognitive/educational/psychological) if available**
- ☐ **A copy of their Referral letter**
- ☐ **Carer/Parent Details:** *including address, contact number and GP address*