

RETT SYNDROME

Request form And clinical informations

The Laboratory is authorized according to the french legislation to perform genetic testing

PATIENT	REFERRING PHYSICIAN
First Name..... Last Name..... Address..... Date of birth/Gender :	Signature :

REQUESTED TEST	INDICATION	
	<input type="checkbox"/> Male patient	<input type="checkbox"/> Female patient
<input type="checkbox"/> <i>MECP2</i> gene analysis	<input type="checkbox"/> Classical Rett syndrome <input type="checkbox"/> Atypical Rett syndrome <input type="checkbox"/> X-linked mental retardation (Xq28) <input type="checkbox"/> Neonatal encephalopathy <input type="checkbox"/> Syndromic mental retardation (hypotony, ataxia, spasticity....)	<input type="checkbox"/> Classical Rett syndrome <input type="checkbox"/> Atypical Rett syndrome <input type="checkbox"/> Angelman syndrome <input type="checkbox"/> Autistic syndrome <input type="checkbox"/> Other non specific mental retardation <input type="checkbox"/> Familial study : mother of an affected girl <input type="checkbox"/> Familial study : asymptomatic sister of an affected girl
<input type="checkbox"/> <i>CDKL5</i> gene analysis	<input type="checkbox"/> Severe/early onset epileptic encephalopathy <input type="checkbox"/> Atypical Rett syndrome (infantile seizure onset)	<input type="checkbox"/> Severe/early onset epileptic encephalopathy <input type="checkbox"/> Atypical Rett syndrome (infantile seizure onset)
<input type="checkbox"/> <i>FOXP1</i> gene analysis	<input type="checkbox"/> Classical Rett syndrome <input type="checkbox"/> Congenital variant of Rett syndrome +/- MRI abnormalities	<input type="checkbox"/> Classical Rett syndrome <input type="checkbox"/> Congenital variant of Rett syndrome +/- MRI abnormalities

CLINICAL INFORMATIONS (according to Neuln et al Ann Neurol 2010 ;68:944-950)

Exclusion criteria and Required criteria for typical or classic RTT

No Yes

<input type="checkbox"/> <input type="checkbox"/> Normal prenatal and perinatal criteria	
<input type="checkbox"/> <input type="checkbox"/> No brain injury secondary to another etiology	
<input type="checkbox"/> <input type="checkbox"/> Normal psychomotor development in first six months of life	
<input type="checkbox"/> <input type="checkbox"/> Partial or complete loss of acquired purposeful hand skills	Age at onset :
<input type="checkbox"/> <input type="checkbox"/> Partial or complete loss of acquired spoken language	Age at onset :
<input type="checkbox"/> <input type="checkbox"/> Stereotypic hand movements	Age at onset :
<input type="checkbox"/> <input type="checkbox"/> Gait abnormalities : Impaired (dyspraxia) or absence of ability	Age at onset :

Other criteria	OTHER INFORMATIONS AND PEDIGREE :
<p>No Yes</p> <input type="checkbox"/> <input type="checkbox"/> Breathing disturbances when awake <input type="checkbox"/> <input type="checkbox"/> Bruxism when awake <input type="checkbox"/> <input type="checkbox"/> Impairment sleep pattern <input type="checkbox"/> <input type="checkbox"/> Abnormal muscle tone - Spasticity <input type="checkbox"/> <input type="checkbox"/> Peripheral vasomotor disturbances <input type="checkbox"/> <input type="checkbox"/> Scoliosis - kyphosis <input type="checkbox"/> <input type="checkbox"/> Growth retardation <input type="checkbox"/> <input type="checkbox"/> Small cold hands and feet <input type="checkbox"/> <input type="checkbox"/> inappropriate laughing or screaming spells <input type="checkbox"/> <input type="checkbox"/> Diminished reponse to pain <input type="checkbox"/> <input type="checkbox"/> Intense eye communication – “eye pointing”	
<input type="checkbox"/> <input type="checkbox"/> Epilepsy <input type="checkbox"/> <input type="checkbox"/> Infantile spasms <input type="checkbox"/> <input type="checkbox"/> Hypotonia <input type="checkbox"/> <input type="checkbox"/> Cerebral abnormalities at MRI <input type="checkbox"/> <input type="checkbox"/> Testicular atrophy <input type="checkbox"/> <input type="checkbox"/> Recurrent infections <input type="checkbox"/> <input type="checkbox"/> Communication dysfunction, automutilation <input type="checkbox"/> <input type="checkbox"/> Postnatal deceleration of head growth <input type="checkbox"/> <input type="checkbox"/> Microcephaly	