UKGTN Testing Criteria

Test name: **Craniosynostosis 3**	
Approved name and symbol of disorder/condition(s): TCF12-Related Craniosynostosis	**OMIM number(s):** TBA
Approved name and symbol of gene(s): transcription factor 12; TCF12	**OMIM number(s):** 600480

Patient name:	**Date of birth:**
Patient postcode:	**NHS number:**
Name of referrer:	
Title/Position:	**Lab ID:**

Referrals will only be accepted from one of the following:	
Referrer	**Tick if this refers to you.**
Consultant clinical geneticist	

Minimum criteria required for testing to be appropriate as stated in the Gene Dossier:	
Criteria	**Tick if this patient meets criteria**
Craniosynostosis affecting at least 1 coronal suture **AND**	
no mutation identified in FGFR1, FGFR2, FGFR3 or TWIST1	
OR at risk family members where familial mutation is known	

Additional Information:

If the sample does not fulfil the clinical criteria or you are not one of the specified types of referrer and you still feel that testing should be performed please contact the laboratory to discuss testing of the sample.