UKGTN Testing Criteria

Test name: Ectodermal Disorders 63 Gene Exome Panel	
Approved name and symbol of disorder/condition(s): See Appendix 1	**OMIM number(s):**
Approved name and symbol of gene(s): See Appendix 1	**OMIM number(s):**

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	
Consultant Adult Dermatologist	
Consultant Paediatric Dermatologist	
Consultant Paediatric Dental Surgeon	

Minimum criteria required for testing to be appropriate as stated in the Gene Dossier:	
Criteria	**Tick if this patient meets criteria**
Congenital/early-onset **AND** consistent abnormalities of at least one of: • Hair – absent/abnormal • Teeth – absent/abnormal • Nails – absent/abnormal • Sweating – absent/decreased • Dermatoglyphics – absent **AND** where dermatophyte infection has been excluded (hair, nails, skin)	

Additional Information:
At risk family members where familial mutation is known do not require a full panel test but should be offered analysis of the known mutation.

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.