

Fill out this form with your doctor and return with the test order to GeneDx.
Or preferably, fill out this form online. Contact PXE International for an ID and password.

Collaboration Education and Test Translation (CETT) Program:
Clinical Data Form for Genetic Testing
Pseudoxanthoma Elasticum (PXE)

Patient name: _____

Date of birth: ____/____/____
mo day yr

Today's date: ____/____/____
mo day yr

Submitting physician: _____

Contact information: _____

Sex: Male Female Age: _____

Weight: lbs: _____ (or kg: _____) Height: ft & in: _____ (or cm: _____)

Ethnicity: Hispanic Non Hispanic Black/African American

American Indian Asian Caucasian Hawaiian/Pacific Islander Mixed

SKIN

Skin lesions: Yes No

Lax/loose skin: Yes No

Areas affected: lateral neck underarm inside elbow groin behind knees

other – describe _____

Skin biopsy performed: Yes No

Site of biopsy: _____

Stain used: _____

Skin biopsy results: Positive Negative Inconclusive Not performed

EYES

Peau d'orange: Yes No Angioid streaks: Yes No

Retinal bleeding: Yes No Vision loss: Yes No

Other eye problems related to PXE: _____

OTHER ORGANS AFFECTED?

Gastrointestinal bleeding: Yes No Other: _____

FAMILY HISTORY

Affected sibling: Yes No How diagnosed: _____

Affected parent: Yes No How diagnosed: _____

Affected grandparent: Yes No How diagnosed: _____

Affected cousin: Yes No How diagnosed: _____

Other affected relative: _____ How diagnosed: _____

Other family information: _____

CONSENT

I consent to release this information to PXE International for research purposes.

Please initial.

Testing recommendations: All individuals with characteristic yellow papules and/or lax redundant skin in the flexural areas (neck, axilla, antecubital or popliteal fossa, groin). All individuals with retinal angioid streaks. Individuals with siblings with confirmed PXE.