Test Request Form

Please provide the following information for all samples submitted to the NPDPSC. Please note that it is very important that you complete the entire form. This information aids the NPDPSC in accomplishing its goal of accurate diagnostics and therefore more complete prion disease surveillance. For more information on our shipping protocols, please visit our website: http://www.cjdsurveillance.com.

1. Attending/Referring Physician*

Name: ___________________ Phone: ___________________ Fax: ___________________

Hospital/Institution: ____________________________________________________________________

Street address: _________________________________________________________________________

City/State/Zip code: ____________________________________________________________________

❖ The physician will be contacted and should be available for any brief telephone inquiry about this case if the testing is positive.

2. Drawing/Sending Laboratory

Name: ___________________ Phone: ___________________ Fax: ___________________

Laboratory/Hospital: ____________________________________________________________________

Street address: _________________________________________________________________________

City/State/Zip code: ____________________________________________________________________

3. Samples enclosed. (Please check all that apply.)

☐ CSF (Please note that we request urine be sent with all CSF samples, if available.)
   *If NPDPSC is to bill patient directly for testing, please also complete and submit the CSF Billing Requisition Form. Otherwise lab will be billed for this test.
   Collection Date: __________

☐ Urine (Urine will only be stored for future research purposes.)
   Collection Date: __________

☐ Blood (Please see our blood protocol for special instructions before sending.)
   Collection Date: __________

☐ Fixed brain biopsy tissue (Range of formic acid should be between 88-98%)
   ☑ Treated in _____% formic acid for 1 hour
   ☑ Sampled (If sampled, follow formic acid treatment with at least 30 minutes in 10% formalin rinse)
   Biopsy Date: __________

☐ Frozen brain biopsy tissue
   ☑ Stored at:  □ -70°C (recommended) □ -20°C □ Refrigerator 4°C
   Biopsy Date: __________

☐ Fixed brain autopsy tissue (Range of formic acid should be between 88-98%)
   ☑ Treated in _____% formic acid for 1 hour
   Autopsy Date: __________

☐ Frozen brain autopsy tissue
   ☑ Stored at:  □ -70°C (recommended) □ -20°C □ Refrigerator 4°C
   Autopsy Date: __________
4. **Patient Information**

Name: ________________________________ ID# __________________

Date of birth: ________________ Sex ______ Race __________________

Onset (month/year): ________________ Date of death (if applicable): ________________

City, state and county of residence: ______________________________________________________

City and state of death (if applicable): ___________________________________________________

5. For all blood and tissue samples sent to the NPDPSC, we REQUIRE that a full clinical history be submitted to aid us in making our diagnosis (if sending blood sample on an asymptomatic patient, you must submit family history). Has clinical history been submitted on this patient?

☐ Yes, it is enclosed in this package ☐ No, it will be sent under separate cover

☐ Yes, it has been submitted previously

6. Has the patient served in the military?

☐ Yes ☐ No

7. Please list patient’s current or previous occupation(s):

____________________________________________________________________________

8. Does the patient have clinical history consistent with any of the following?

☐ Rapid dementia ☐ Cerebral infarction ☐ Acute brain trauma

☐ Brain lymphoma ☐ Paraneoplastic encephalopathy

☐ Viral encephalitis ☐ Asymptomatic (for blood samples)

9. Does the patient have any family history of CJD or early onset dementia? If yes, please submit information on family history.

☐ Yes, CJD ☐ Yes, early onset dementia ☐ No

10. Please check if the patient may have any risk for the iatrogenic form of CJD due to the following factors:

☐ Human growth hormone (hGH) ☐ Human pituitary gonadotrophin (hGNH)

If either box above is checked, please list start and end dates of treatment:

___________________________________________________________________________

☐ Intradural brain or spinal cord surgery. Please list date and location of surgery:

___________________________________________________________________________

☐ Dura mater graft. Please list date and location of graft: ___________________________

☐ Corneal transplant. Please list date and location of transplant: _____________________

11. Does the patient have a known history of foreign travel or eating wild game?

☐ Yes, foreign travel: Where and when?

☐ Yes, patient consumed wild game: What type and from what state(s)?

☐ Yes, patient has a known history of hunting wild game: What state(s) and when?

12. Did the patient donate blood?

☐ Yes: In what year(s) and city/state? _____________________________________________

☐ No