

Test Request Form

Please provide the following information for all samples submitted to the NPDPS, 2085 Adelbert Road, Room 418, Cleveland, OH 44106-4907. **Please note that it is required that you complete the entire form.** This information aids the NPDPS 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*

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 NPDPS 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 in 10% neutral buffered formalin

Treated in _____% formic acid for 30 mins (Range of formic acid should be between 88-98%).
Follow formic acid treatment with 10% formalin rinse.

Biopsy Date: _____ please check here if untreated with formic acid

- Frozen brain biopsy tissue

↳ Stored at: -70°C (recommended) -20°C Refrigerator 4°C

Biopsy Date: _____

- Fixed brain autopsy tissue in 10% neutral buffered formalin for 2 weeks before sending

Grossed Not grossed (if not grossed, do not treat with formic acid)

Grossed & Treated in _____% formic acid for 1 hour (Range of formic acid should be between 88-98%).
(If grossed and treated, follow formic acid treatment with 10% formalin rinse)

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: _____ Current /previous occupations: _____

City and state of death (if applicable): _____

5. For all blood and tissue samples sent to the NPDPS, 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. Does the patient have clinical history consistent with any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Rapid dementia | <input type="checkbox"/> Cerebral infarction | <input type="checkbox"/> Acute brain trauma |
| <input type="checkbox"/> Brain lymphoma | <input type="checkbox"/> Paraneoplastic | <input type="checkbox"/> Asymptomatic (for blood samples) |
| <input type="checkbox"/> Viral encephalitis | <input type="checkbox"/> encephalopathy | |

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

- No Yes, early onset dementia Yes, CJD (describe relationship below)

9. 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: _____

10. 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? _____

11. Did the patient donate/receive blood? No Unknown

Yes, donated : In what year(s) and city/state? _____

Yes, received: In what year(s) and city/state? _____