National Prion Disease
Pathology Surveillance Center

CSF TEST REQUISITION FORM

NPDPSC Institute of Pathology, CWRU
2085 Adelbert Rd, Room 414
Cleveland, Ohio, 44106-4907

Phone: 216-368-0587
Fax: 216-368-2546
Email link: https://securemail.case.edu/encrypt
priondiagnostics@case.edu

Patient Information (required)

Patient ID (MRN#):		
Last Name:	First Name:	
Sex: ☐ Male ☐ Female	Date of Birth *(mm-dd-yyyy)*:	
Race:	Hispanic/Latino: ☐ Yes ☐ No	
Patient Address:		
City:	State:	Zip Code:

Ordering Provider (required)

Ordering Provider Name:		
Hospital/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number:	ICD-10 Diagnosis Code:	

* Fax number given must comply with applicable HIPAA regulations

Referring Laboratory

Contact Person:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number:	ICD-10 Diagnosis Code:	

Accounts Payable/Billing Information *(if applicable)*

☐ **Check here** if AP/Billing information is the same as Referring Laboratory. Otherwise, please fill out the information below.

Name:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:

Primary Insurance Information *(if applicable)*

☐ **Check here** If we are to bill the patient directly.
Please fill out the information below and **include a copy of the front and back of the insurance card.**

Subscriber Name (if different than patient):		
Insurance Name:	Effective Date *(mm-dd-yyyy)*:	
Policy Number:	Group Number:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:		
Insurance Company Address:		
City:	State:	Zip Code:

Clinical Chemistry

☐ **Cerebrospinal Fluid**
(RT-QuIC, 14-3-3γ (ELISA), Total TAU (ELISA)

Collection Date: _____
(mm-dd-yyyy)

Preferred Container
Polypropylene (PP), low binding, sterile collection tube.

Shipping
Frozen. Shipping transport on dry ice.

For shipping and contact information on clinical samples please visit
https://case.edu/medicine/pathology/divisions/national-prion-disease-pathology-surveillance-center/resources-professionals/contact-and-shipping-information

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Clinical, Family and Social History

To be completed by the requesting clinician. Also, please attach or send a clinician's assessment from the EMR.

Clinical Suspicion of Prion Disease

On a scale 1-10, with 1 being LOW and 10 being HIGH, what is the clinical suspicion of prion disease?

Please check one of the boxes:

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Clinical Symptoms

*Please indicate the symptom onset (mm/yyyy)

☐ Dementia: _____
☐ Ataxia: _____
☐ Myoclonus: _____
☐ Visual Changes: _____
☐ Extrapyramidal: _____
☐ Pyramidal: _____
☐ Psychiatric: _____
☐ Other: _____

Family History

CJD in Family

Is there a Family history of Prion Disease?
☐ Yes
☐ No

If **yes**, what type of Prion Disease?
☐ CJD
☐ GSS
☐ FFI
☐ Other: _____

Relationship to patient:

Neurological Diseases in Family

Is there a Family history of Neurological Disease?
☐ Yes
☐ No

If **yes**, what type of Disease?
☐ Alzheimer's
☐ Other: _____

Relationship to patient:

Social History

Hunting

Has patient ever **hunted** venison? ☐ Yes ☐ No

Venison Type: *(check all that apply)*
☐ Deer
☐ Elk
☐ Moose
☐ Caribou

State/Province:

Year(s):

Consumption

Has patient ever **consumed** venison? ☐ Yes ☐ No

Venison Type: *(check all that apply)*
☐ Deer
☐ Elk
☐ Moose
☐ Caribou

State/Province:

Year(s):

Travel

Has patient ever travelled to UK, Europe, or Saudi Arabia between years 1980-1996?
☐ Yes
☐ No

Countries:

Year(s):

Radiographic Findings

NPDPSC offers MRI interpretation at no cost. For assessment, please send brain MRI on disc to our mailing address.

Has patient had MRI suggestive of CJD?
☐ Yes
☐ No
☐ Not performed

Has patient had EEG with periodic sharp wave complexes?
☐ Yes
☐ No
☐ Not performed

Medical & Surgical History

RT-QuIC Results

Patient's RT-QuIC Results:
☐ Positive
☐ Negative
☐ Indeterminate
☐ Not Performed

Blood Transfusions

Has patient ever received blood?
☐ Yes
☐ No

Facility:

Year(s):

Surgical Procedures

Has the patient had any of these procedures?

Check all that apply:
☐ Neurosurgery
☐ Corneal transplant
☐ Dura mater graph
☐ None

Procedure facility: _____

Date: _____
(mm-dd-yyyy)

Medical Treatment

Has the patient had any of these treatments?

Check all that apply:
☐ Pituitary gonadotropin
☐ Human growth hormone
☐ None

Procedure facility: _____

Date: _____
(mm-dd-yyyy)