

## Test Request Form

Please provide the following information for all samples submitted to the NPDPS. Please note that it is very important that you complete the entire form to aid the NPDPS in providing an accurate diagnosis. For more information on why we require this data, please see our website (<http://www.cjdsurveillance.com>).

### 1. Drawing/Sending Laboratory

Your name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Laboratory/Hospital: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip code: \_\_\_\_\_

### 2. Samples enclosed. *(Please check all that apply.)*

- CSF *(Please note that we request urine be sent with all CSF samples, if available.)*
- Urine *(Urine will only be stored for future research purposes.)*
- 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)*
- Frozen brain biopsy tissue
  - Stored at:  70°C *(recommended)*  20°C  Refrigerator 4°C
- Fixed brain autopsy tissue *(Range of formic acid should be between 88-98%)*
  - Treated in \_\_\_\_\_% formic acid for 1 hour.
- Frozen brain autopsy tissue
  - Stored at:  70°C *(recommended)*  20°C  Refrigerator 4°C
- Blood *(Please see our blood protocol for special instructions before sending blood.)*

### 3. Is additional tissue available on this patient?

- No
- Yes – Please describe. \_\_\_\_\_

### 4. To whom should test results be submitted? *(Please check all that apply.)*

- Drawing laboratory
- Referring physician

5. **Referring Physician**

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Hospital/Institution: \_\_\_\_\_

Street address: \_\_\_\_\_

City/State/Zip code: \_\_\_\_\_

6. For all samples sent to the NPDPS, we REQUIRE that a full clinical history be submitted to aid us in making our diagnosis. Has a clinical history been submitted?
- Yes, it is enclosed in this package
  - Yes, it has been submitted previously
  - No, it will be sent under separate cover

7. **Patient Information**

Name: \_\_\_\_\_ ID# \_\_\_\_\_

Date of birth: \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Onset (*month/year*): \_\_\_\_\_ Date of death (*if applicable*): \_\_\_\_\_

City and state of residence: \_\_\_\_\_

City and state of death (*if applicable*): \_\_\_\_\_

8. Does the patient have any military experience?
- Yes
  - No
9. Does the patient have a history of any of the following?
- Herpes encephalitis
  - Cerebral infarction
  - Other viral encephalitis
  - Acute brain trauma
  - None of the above
10. Does the patient have any family history of CJD or early onset dementia?
- Yes, CJD
  - No
  - Yes, early onset dementia
11. Does the patient have a known history of foreign travel or eating wild game?
- Yes, foreign travel: Where? \_\_\_\_\_
  - Yes, patient ate wild game or was a hunter
  - No, patient did not engage in either of these activities
12. Did the patient donate blood?
- Yes – In what year and city: \_\_\_\_\_
  - No