

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.** 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 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.)

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

8. 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 |
| <input type="checkbox"/> Viral encephalitis | encephalopathy | 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