



National Prion Disease
Pathology Surveillance Center

CSF TEST REQUISITION FORM

NPDPS 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm-dd-yyyy):	
Race:	Hispanic/Latino: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other:		
Insurance Company Address:		
City:	State:	Zip Code:

Clinical Chemistry

Cerebrospinal Fluid

(RT-QuIC, 14-3-3y (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.

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: Deer
 (check all that apply) Elk
 Moose
 Caribou

State/Province:

Year(s):

Consumption

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

Venison Type: Deer
 (check all that apply) 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

NPDPS 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)