2405 Wesbrook Mall, room 5524
Vancouver BC
V6T 1Z3
www.neurocode.com

Epilepsy Test Requisition Form

Ordering Physician

Last Name | First Name | Billing #

Address

City | Province | Postal Code

Phone | Fax

Copy Physician/Genetic Counsellor | Billing #

Phone | Fax

Copy Physician/Genetic Counsellor | Billing #

Phone | Fax

Patient Information

Last Name | First and Middle Names

Date of Birth (DD/MMM/YYYY) | PHN

Gender

☐ Male ☐ Female ☐ Unknown

Address

City | Province | Postal Code

Ethnicity (check all that apply):

☐ African ☐ Ashkenazi ☐ Asian ☐ Caucasian ☐ Indigenous
☐ Hispanic ☐ Other, please specify:

Sample Type

☐ Whole Blood (in EDTA)
Adult: 3mL minimum
Pediatric: 1mL minimum
☐ Oral Rinse: 30mL minimum
☐ DNA – source:

Collection Details

Date Collected (DD/MMM/YYYY) | Collector's Initials

Time Collected (HH:MM)

COLLECTION LAB LABEL ONLY

Samples are NOT accepted if the answer to either question is "Yes":

- Has the patient had a blood transfusion within 2-4 weeks of specimen collection? ☐ Yes ☐ No
- Has the patient had an allogenic bone marrow transplant? ☐ Yes ☐ No

Test Selection

☐ Targeted Epilepsy Whole Exome Sequencing + Sanger Validation
☐ Re-analysis (at least one year after initial analysis)

Referral Approval (if Ordering Physician is not a BCCH Pediatric Neurologist)

See page 5 Requisition instructions

Signature | Date (DD/MMM/YYYY)

Print Name | Billing #

Neurocode Labs Use Only

Receiver's Name:

Receive Date (DD/MMM/YYYY):

Neurocode Labs Label

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Clinical History

☒ Epilepsy/Seizure Disorder

Seizure History

Age at first unprovoked seizure: _____months

Has this patient been diagnosed with an epilepsy syndrome? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Epileptic encephalopathy? ☐ Yes ☐ No ☐ Unknown

Developmental History ☐ N/A

Developmental delay? ☐ Yes ☐ No ☐ Unknown
If yes, preceding seizure onset? ☐ Yes ☐ No

Type of delay (choose all that apply):
- ☐ Gross/fine motor
- ☐ Speech/language
- ☐ Cognitive
- ☐ Adaptive
- ☐ Social Emotional
- ☐ Global

Regression or plateau? ☐ Yes ☐ No ☐ Unknown

Intellectual disability? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ *Mild ID*
☐ *Moderate ID*
☐ *Severe ID*

ADHD? ☐ Yes ☐ No ☐ Unknown

Autism spectrum disorder? ☐ Yes ☐ No ☐ Unknown

Neuropsychiatric comorbidity? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Neurological Exam ☐ N/A

Head circumference abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ *Microcephaly*
☐ *Macrocephaly*

Motor exam abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

EEG abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

MRI abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Visual / eye abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other Cranial Nerve abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other phenotypic abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Describe Other Relevant Clinical Information ☐ N/A

History of an acquired brain injury? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other Medical Conditions? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Metabolic testing abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Single/Multi-gene testing abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other genetic testing? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Microarray abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

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Family History of Neurological Disorders

☐ No Known Family History
☐ Adopted

Relationship	Gender	Maternal	Paternal	Neurological Disorder	Age at Dx
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		

Other Relevant Family History

Physician's Statement and Signature

*This test is **medically necessary** for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results could direct medical management and treatment decisions. By my signature below, I indicate that I am the referring physician and/or authorized health care provider. I have explained the purpose, possible results (including incidental findings), and limitations of the test described above. The patient and/or patient's legal guardian has been given the opportunity to ask questions and/or seek genetic counseling. The patient, or the patient's legal guardian, has given informed consent for the test described above to be performed. By my signature below, I also indicate that the patient is eligible for testing (see page 4).*

Ordering Physician's Signature	Date (DD-MMM-YYYY)

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MSP Clinical Criteria Summary for Targeted Epilepsy Whole Exome Sequencing

To be eligible for testing, patients must meet the following criteria:

1. Age 19 or younger
2. One or more inclusion criteria
3. No exclusion criteria

Inclusion

A. When the clinical features (age of onset, seizure semiology, and EEG features) are consistent with a distinct electroclinical syndrome as defined by the International League Against Epilepsy (ILAE), with the exception of benign childhood or older epilepsy syndromes (see exclusion criteria).
B. When the prognosis based on clinical and EEG findings is poor or the likelihood of lethal outcome is high.
C. When epileptic seizures are refractory to medical treatment as defined by the ILAE.
D. When epilepsy is associated with features suggestive of treatable inborn errors of metabolism.
E. When epilepsy is associated with distinctive patterns of malformations of cortical development identified on neuroimaging studies.
F. When epilepsy is associated with clinical signs of neurodegeneration.
G. When epilepsy is associated with paroxysmal neurological features.
H. When epilepsy is associated with additional syndromic features such as developmental delay, intellectual disability, multiple congenital anomalies, dysmorphic features.
I. When familial epilepsy is present, defined as at least 2 first-degree family members with related epilepsy syndromes, unless the epilepsy syndrome is benign (childhood or later onset-see exclusion criteria).

Exclusion

A. Recognizable seizure syndrome with benign course (exception self-limited (familial) neonatal or infantile epilepsy syndromes).
    i. Benign childhood epilepsy with central temporal spikes-typical presentations
    ii. Typical childhood absence epilepsy
    iii. Juvenile myoclonic epilepsy controlled on medications and without intellectual disability or signs of neurodegeneration
B. Mesial temporal lobe epilepsy with hippocampal sclerosis
C. Acquired Epilepsy eg post-traumatic, brain infection, tumor, etc

The document, *Criteria for Whole Exome Sequencing in Children with Seizure Disorders of Unknown Etiology in British Columbia*, which outlines the full inclusion and exclusion criteria, can be obtained by contacting the BC Children's Hospital Division of Neurology or BC's Agency for Pathology and Laboratory Medicine.

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Requisition Instructions

Instructions for the proper completion of the test requisition can be found on our website at http://www.neurocode.com/tests.html, under the "Test Requisition Form" section.

If ordering physician is not a BC Children's Hospital pediatric neurologist, please contact Drs. Michelle Demos, Cyrus Boelman or Mary Connolly via paging at BC Children's Hospital (604-875-2161) for referral approval. Completed requisitions should be faxed to 604-875-2285 for referral approval signatures. "Neurocode Epilepsy Referral Approval" should appear in the fax subject line and return fax information is required.

Collection Instructions

Instructions for the proper collection of specimens can be found on our website at http://www.neurocode.com/tests.html, under the "Sending Samples" section.

Shipping Instructions

Samples should be shipped according to IATA, ICAO and TDG regulations. ***All samples should be transported at room temperature and shipped on the same day or as soon as possible after sample collection/processing.*** If possible, samples should be collected Monday to Wednesday to ensure delivery to our facility before the weekend.

Sample handling/storage information prior to shipping:

Blood - samples can be stored at 4˚C (for no longer than 3-4 days) or at -20˚C for longer periods
Oral rinse – samples should be stored at 4˚C until ready for transport
DNA - should be stored at -20˚C until ready for transport

Packages should include:

1) Labelled sample(s) (with subject's initials, PHN and sample collection date)
2) The corresponding completed test requisition

Please note: samples that do not meet the requirements listed at http://www.neurocode.com/samples.html *will be rejected*. Incomplete test requisitions will result in testing delays, or possible sample rejection.

Ship samples to the following address:

Neurocode Labs, Inc.
Attn: Ilaria Guella
Room 5524, 2405 Wesbrook Mall
Vancouver, BC
Canada V6T 1Z3

If you have any questions regarding sample collection/processing and shipping, please contact us at info@neurocode.com.