Neuroimmunology Assay Requisition

Highlighted fields must be filled. Failure to complete requisition will result in delayed results delivery.

For Neurocode Lab use only

Date Received: _____

Time Received: _____

Recipient: _____

This requisition form, when completed, constitutes a referral to the Neurocode USA Inc. It is for the use of authorized health care providers only.

PATIENT INFORMATION

LAST NAME

FIRST NAME | MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY) | SEX ☐ Male ☐ Female ☐ Other/Unknown

TELEPHONE NUMBER | E-MAIL

ADDRESS

CITY / STATE / ZIP

☐ **Check to request Sample Collection Kit shipped to patient address.**

ACKNOWLEDGEMENT: I authorize the laboratory to provide to my health plan the information on this form and other information provided by my healthcare provider if necessary for reimbursement. I understand that the laboratory may seek prior authorization for testing from my health plan on my behalf. I also authorize all benefits of the plan to be payable directly to the laboratory, and I agree to remit to the laboratory any payment for these services made directly to me. I understand that the laboratory may be an out-of-network provider for my health plan and that I may be responsible for all amounts not reimbursed by my health plan. I hereby designate the laboratory as my Authorized Representative, as provided under ERISA, 29 C.F.R. § 2560.5031 (b)(4), and/or as my Attorney in Fact, for the purpose of pursuing administrative appeals to which I am entitled and, if the laboratory deems it appropriate, any legal and/or equitable claims that I could bring against my health plan, and/or its fiduciaries, and/or its administrators, with respect to their handling or resolution of my insurance claim.

PATIENT SIGNATURE | DATE (MM/DD/YY)

X

REFERRING PHYSICIAN

PHYSICIAN NAME & NPI # (IF APPLICABLE)

CLINIC / FACILITY NAME

ADDRESS

CITY / STATE / ZIP

TELEPHONE NUMBER

RESULTS DELIVERY METHOD

RESULTS ARE DELIVERED BY WEB PORTAL. PLEASE PROVIDE EMAIL FOR PORTAL ACCESS

Email: _____

ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the tests(s) requested herein.

REQUIRED ORDERING CLINICIAN SIGNATURE | DATE (MM/DD/YY)

X

BILLING INFO

► **Please provide CLINIC NOTES to support medical necessity for insurance purposes.** ◄
FAX to 360-543-6853 or EMAIL CustomerCare@neurocode.com

☐ **BILL INSURANCE** Attach legible front and back copy of insurance cards.

INSURANCE COMPANY

IPA NAME | MEMBER ID

☐ **BILL PATIENT** Patient will be contacted to provide payment method.

☐ **BILL CLINIC** (Client billing arrangement required)

REFERRED LABORATORY TESTS

MYASTHENIA GRAVIS

☐ Antibodies to AChR (adult and fetal) **by live cell-based assay (CBA)**

☐ MG Reflex panel: AChR **by radioimmunoprecipitation (RIPA)** with reflex to AChR **by live CBA** and MuSK **by RIPA** *(MG Reflex panel requires Client Billing Agreement. Contact Neurocode to set up an account.)*

☐ dSN-MG Reflex: Antibodies to LRP4 **by fixed cell based assay (CBA)**

REQUIRED DIAGNOSTIC INFORMATION (ICD-10) (Check all that apply)

☐ G70.00 Myasthenia gravis without (acute) exacerbations	☐ G70.9 Myoneuronal disorder, unspecified	☐ G37.8.1 MOG antibody disorder	☐ G13. 0 Paraneoplastic neuromyopathy
☐ G70.01 Myasthenia gravis with (acute) exacerbations	☐ G70.80 Lambert-Eaton syndrome, unspecified	☐ G61.8.1 CIDP	☐ Other: _____
☐ G70.8 Other specified myoneuronal disorders	☐ G36.0 Neuromyelitis optica	☐ G04.8.1 Other encephalitis	☐ Other: _____

ADDITIONAL CLINICAL INFORMATION

☐ Ocular ☐ Generalized ☐ Clinical Remission

Double vision? ☐ Yes ☐ No

Difficulty swallowing? ☐ Yes ☐ No

Generalized weakness? ☐ Yes ☐ No

Fatiguable weakness? ☐ Yes ☐ No

Repetitive Nerve Stimulation (RNS):	☐ Normal	☐ Abnormal	☐ Unknown
Single-Fiber Electromyography (SFEMG):	☐ Normal	☐ Abnormal	☐ Unknown
Beneficial effect of mestinon?	☐ Yes	☐ No	☐ Unknown
Thymoma?	☐ Yes	☐ No	☐ Unknown

List any previous Ab tests performed:

Current Treatment(s):

Date of last administration: _____

SPECIMEN INFORMATION – REQUIRED (This section to be completed at sample collection.)

COLLECTION DATE (MM/DD/YY) | COLLECTION TIME (HH:MM) ☐ AM ☐ PM | SPECIMEN TYPE ☐ Serum

COLLECTION LOCATION | COLLECTION PHONE | COLLECTION EMAIL

Label all specimens with patient full name, DOB, and sample collection date:

SERUM: Draw blood in SST for 2-5mL serum. Spin tubes, aliquot serum, store at 2°C-8°C. Freeze ice packs and package with aliquots for shipping. ***Ship within 72 hours of collection. See included instructions for more detail.***

OTHER COMMENTS (Diagnosis and/or Special Treatments, e.g. patient on IVIG)

SHIPPING & DELIVERY INSTRUCTIONS

- Package should include labelled samples and completed and signed requisition forms. Samples should be shipped in accordance to IATA, ICAO, and FDA regulations.
- No weekend and statutory holiday deliveries (New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, & Christmas)
- To ensure sample viability all samples should be shipped Monday-Friday
- Delivery Address: **ATTN: Neurocode, 3548 Meridian St, Suite 101, Bellingham, WA 98225**
- **FAX REQUISITION TO (360) 543-6853**