Neurology 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.**

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: _____

BILLING INFO

☐ **BILL CLINIC** Clinic billing arrangement required

CLIENT NAME | CONTACT E-MAIL

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

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 X | DATE (MM/DD/YY)

REFERRED LABORATORY TESTS

NEURODEGENERATIVE DISORDERS (REQUIRED)

Blood Tests

- ☐ Plasma p-tau 217
- ☐ Plasma Nf-L
- ☐ Plasma GFAP
- ☐ Plasma Aβ42/40 ratio (RUO)
- ☐ APOE (RUO)

Cerebrospinal Fluid Tests (Lumbar Puncture)

- ☐ CSF Aβ42/40 ratio
- ☐ CSF panel: Aβ42/40, Total tau, p-tau 181, and Nf-L

ADDITIONAL CLINICAL INFORMATION (please check):

APOE: ☐ Unknown ☐ 2/2 ☐ 2/3 ☐ 2/4 ☐ 3/3 ☐ 3/4 ☐ 4/4

Chronic Kidney Disease (CKD):	☐ Yes	☐ No	☐ Unknown
Hypertension:	☐ Yes	☐ No	☐ Unknown
Diabetes:	☐ Yes	☐ No	☐ Unknown
History of cancer:	☐ Yes	☐ No	☐ Unknown
History of stroke:	☐ Yes	☐ No	☐ Unknown
History of myocardial infarction:	☐ Yes	☐ No	☐ Unknown

(SECTION BELOW TO BE COMPLETED AT SAMPLE COLLECTION)

REQUIRED SPECIMEN INFORMATION

COLLECTION DATE (MM/DD/YY)	COLLECTION TIME (HH:MM) ☐ AM ☐ PM	SPECIMEN TYPE ☐ Plasma ☐ CSF
COLLECTION LOCATION	COLLECTION PHONE	COLLECTION EMAIL

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

PLASMA: Draw blood in K2 EDTA for 2-5mL plasma. Spin tubes immediately (refrigerated preferred), aliquot plasma, store refrigerated (4°C). ***Must ship within 24 hours of collection.*** Package on frozen cold packs for shipment.

CSF: Aliquot ***before freezing*** into multiple 5mL Sarstedt tubes, ***minimum of two tubes required, min 1.5mL each***. Freeze immediately after aliquoting (-80°C preferred). Avoid freeze-thaw cycles or multiple tube transfers. Package on dry ice for shipment (see draw instructions for additional details).

SHIPPING & DELIVERY INSTRUCTIONS

- Package according to sample requirements. Send via Priority Overnight shipping.
  - Plasma must be shipped on cold packs within 24 hours of collection.
  - CSF must be shipped on dry ice. Package must include Class 9 label; write net weight of dry ice in (in kilograms).
- Packages should include labelled samples (name and DOB) 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 Sunday-Friday.
- Delivery Address: **ATTN: Neurocode**
  3548 Meridian St, Suite 101
  Bellingham, WA 98225
  CustomerCare@neurocode.com

FAX REQUISITIONS TO (360) 543-6853