



neurocode

Alzheimer's Disease Requisition

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.

Highlighted fields must be completed to avoid delays in sample processing.

PATIENT INFORMATION		REFERRING PHYSICIAN	
LAST NAME		PHYSICIAN NAME & NPI # (IF APPLICABLE)	
FIRST NAME		CLINIC / FACILITY NAME	
MIDDLE NAME		ADDRESS	
DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other/Unknown	CITY / STATE / ZIP	
PATIENT MRN		TELEPHONE NUMBER	FAX NUMBER
TELEPHONE NUMBER		PREFERRED RESULTS DELIVERY METHOD <input type="checkbox"/> Fax <input type="checkbox"/> Secure Email: _____	
E-MAIL	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 test(s) requested herein.		
ADDRESS	REQUIRED >>> X		ORDERING CLINICIAN SIGNATURE _____ DATE (MM/DD/YY) _____
CITY / STATE / ZIP	BILLING INFO		
<input type="checkbox"/> BILL CLINIC Clinic billing arrangement required			
CLIENT NAME _____			
CONTACT E-MAIL _____			
<input type="checkbox"/> BILL PATIENT Patient will be contacted to provide payment method.			
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 X	DATE (MM/DD/YY) _____		
REQUIRED SPECIMEN INFORMATION			
COLLECTION DATE (MM/DD/YY)	COLLECTION TIME (HH:MM) <input type="checkbox"/> AM <input type="checkbox"/> PM	SPECIMEN TYPE <input type="checkbox"/> Plasma <input type="checkbox"/> 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).

REQUIRED DIAGNOSTIC INFORMATION (ICD-10) (Check all that apply)			
<input type="checkbox"/> G30.0 Alzheimer's disease with early onset	<input type="checkbox"/> G30.9 Alzheimer's disease, unspecified	<input type="checkbox"/> G31.0 Frontotemporal dementia	<input type="checkbox"/> I21 Myocardial Infarction
<input type="checkbox"/> G30.1 Alzheimer's disease with late onset	<input type="checkbox"/> G35 Multiple Sclerosis	<input type="checkbox"/> G20 Parkinson's disease	<input type="checkbox"/> S06 Intracranial injury
<input type="checkbox"/> G30.8 Other Alzheimer's disease	<input type="checkbox"/> G12.2.1 Amyotrophic lateral sclerosis	<input type="checkbox"/> I63 Cerebral infarction	<input type="checkbox"/> Other: _____
REFERRED LABORATORY TESTS			
NEURODEGENERATIVE DISORDERS	REQUIRED CLINICAL INFORMATION (please check):		
<input type="checkbox"/> CSF Aβ42/40	<input type="checkbox"/> Suspected AD <input type="checkbox"/> MCI <input type="checkbox"/> Unknown Dementia <input type="checkbox"/> Stroke/TBI <input type="checkbox"/> Other: _____		
<input type="checkbox"/> CSF panel: Aβ42/40, Total tau, p-tau 181, and Nf-L	APOE: <input type="checkbox"/> Unknown <input type="checkbox"/> 2/2 <input type="checkbox"/> 2/3 <input type="checkbox"/> 2/4 <input type="checkbox"/> 3/3 <input type="checkbox"/> 3/4 <input type="checkbox"/> 4/4		
<input type="checkbox"/> Plasma p-tau 217	Chronic Kidney Disease (CKD): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Plasma Nf-L	Hypertension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Plasma GFAP (for research use only)	Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Plasma p-tau 181 (for research use only)	History of cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
OTHER COMMENTS	History of stroke: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	History of myocardial infarction: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
	Body Mass Index (BMI): _____		

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 Monday-Thursday
- Delivery Address: **ATTN: Neurocode**
3548 Meridian St, Suite 101
Bellingham, WA 98225
CustomerCare@neurocode.com

FAX REQUISITIONS TO (360)-527-4596