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

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH (MM/DD/YYYY)

SEX ☐ Male ☐ Female ☐ Other/Unknown

PATIENT MRN

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

X

DATE (MM/DD/YY)

REFERRING PHYSICIAN

PHYSICIAN NAME & NPI # (IF APPLICABLE)

CLINIC / FACILITY NAME

ADDRESS

CITY / STATE / ZIP

TELEPHONE NUMBER

FAX NUMBER

PREFERRED RESULTS DELIVERY METHOD

☐ Fax ☐ Secure 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

X

DATE (MM/DD/YY)

BILLING INFO

☐ **BILL CLINIC** Clinic billing arrangement required

CLIENT NAME

CONTACT E-MAIL

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

REFERRED LABORATORY TESTS

NEURODEGENERATIVE DISORDERS

- ☐ Plasma p-tau 217
- ☐ Plasma Nf-L
- ☐ Plasma GFAP (for research use only)
- ☐ CSF Aβ42/40
- ☐ CSF panel: Aβ42/40, Total tau, p-tau 181, and Nf-L

OTHER COMMENTS

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

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

FAX REQUISITIONS TO (360) 543-6853