National Prion Disease
Pathology Surveillance Center

TEST REQUISITION FORM

For NPDPSC use only

Patient Information (required)

Patient ID (MRN#):		
Last Name:	First Name:	
Sex: ☐ Male ☐ Female	Date of Birth *(mm-dd-yyyy)*:	
Race *(select from the drop-down list)*:	Hispanic/Latino Ethnicity: ☐ Yes ☐ No	
Patient Address:		
City:	State:	Zip Code:
Is patient deceased? ☐ Yes ☐ No	Is there interest in the Autopsy Program? ☐ Yes ☐ No	
Date of Death *(mm-dd-yyyy)*:	Time of Death: ☐ am ☐ pm	

Note: CDC-sponsored brain autopsy is available to definitely diagnose or exclude prion disease. Call 216-368-0587 for details.

Ordering Provider (required)

Ordering Provider Name:		
Hospital/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number :	ICD-10 Diagnosis Code:	

Note: Results will be transmitted to Ordering Provider via fax only.

Referring Laboratory

Contact Person: **Referral Testing**		
Laboratory/Institution: **ARUP Laboratories**		
Phone: **801-583-2787 ext. 5145**	Fax*: **801-584-5132**	
Street Address: **500 Chipeta Way**		
City: **Salt Lake City**	State: **UT**	Zip Code: **84108**
NPI Number :	ICD-10 Diagnosis Code:	

Note: Results will be transmitted to the Referring Lab via fax only.

Accounts Payable/Billing Information *(if applicable)*

✔ **Check here** if AP/Billing information is the same as **Referring Laboratory**. Otherwise, please fill out the information below.

Name: **Referral Testing**		
Laboratory/Institution: **ARUP Laboratories**		
Phone: **801-583-2787 ext. 5145**	Fax*: **801-584-5132**	
Street Address: **500 Chipeta Way**		
City: **Salt Lake City**	State: **UT**	Zip Code: **84108**

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Samples Enclosed (required)

Cerebrospinal Fluid

☐ **Cerebrospinal Fluid Panel**
(RT-QuIC, 14-3-3γ (ELISA), Total TAU (ELISA)

Collection Date *(mm-dd-yyyy)*: _____

Volume *(enter number)*: _____ ml.

Whole Blood

☐ **Blood** *(PRNP Genetic Testing)*
***Note**: Testing & Reporting Policies Form **must** be completed and submitted with this form.*

Collection Date *(mm-dd-yyyy)*: _____

Volume *(enter number)*: _____ ml

Biopsy Tissue

☐ **Frozen Brain** *(Western Blot)*

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Other: _____ ☐ mg ☐ gr

☐ **Fixed Brain**
(Immunohistochemistry (IHC), Hematoxylin & Eosin staining (H&E))

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Unstained Slides: #_____
☐ Cassettes: #_____
☐ Paraffin Embedded Blocks #_____

Autopsy Tissue

☐ **Frozen Brain** *(Western Blot)*

Collection Date *(mm-dd-yyyy)*: _____

Amount: ☐ Whole Brain
☐ Half Brain
☐ Other: _____ ☐ mg ☐ gr

☐ **Fixed Brain**
(Immunohistochemistry (IHC), Hematoxylin & Eosin staining (H&E))

Collection Date *(mm-dd-yyyy)*:

Amount: ☐ Whole Brain
☐ Half Brain
☐ Unstained Slides: #_____
☐ Cassettes: #_____
☐ Paraffin Embedded Blocks #_____

Skin, Lymphoreticular

☐ **Skin Sample**

Collection Date *(mm-dd-yyyy)*: _____

☐ Apex
☐ Posterior to ear
☐ Lumbar spine

☐ **Lymphoreticular Tissue**

Collection Date *(mm-dd-yyyy)*: _____

☐ Appendix
☐ Visceral Lymph Nodes
☐ Spleen

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Clinical History and Findings (required)

To be completed by the requesting physician. Also, please attach a clinician's assessment from the EMR.

Clinical Suspicion of Prion Disease

On a scale 1-10, with 1 being LOW and 10 being HIGH, what is the clinical suspicion of prion disease?

Please check one of the boxes:

1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Medical & Surgical History

Blood Donations

Has patient ever donated blood? ☐ Yes ☐ No

If yes, donation institution:

Donation year: _____

Do you agree to be contacted by the American Red Cross? ☐ Yes ☐ No

Blood Transfusions

Has patient ever received blood? ☐ Yes ☐ No

If yes, transfusion institution:

Transfusion year: _____

Surgical Procedures

Has the patient had any of these procedures?
Check all that apply:

☐ Neurosurgery
☐ Corneal transplant
☐ Dura mater graft
☐ None

Procedure facility: _____

Date *(mm-dd-yyyy)*: _____

Medical Treatment

Has the patient had any of these treatments?
Check all that apply:

☐ Pituitary gonadotropin (cadaveric)
☐ Human growth hormone (cadaveric)
☐ None

Procedure facility: _____

Date *(mm-dd-yyyy)*: _____

Clinical Symptoms

Illness Onset *(mm/yyyy)*:

☐ Dementia, onset: _____
☐ Ataxia, onset: _____
☐ Myoclonus, onset: _____
☐ Visual Changes, onset: _____
☐ Extrapyramidal, onset: _____
☐ Pyramidal, onset: _____
☐ Psychiatric, onset: _____
☐ Other: _____

Radiographic Findings

NPDPSC offers MRI interpretation at no cost. For assessment, please send brain MRI on disc to our mailing address.

Has patient had MRI suggestive of CJD?

☐ Yes ☐ No ☐ Not performed

Has patient had EEG with periodic sharp wave complexes?

☐ Yes ☐ No ☐ Not performed

Family History

Prion Disease in Family

Is there a Family History of Prion Disease? ☐ Yes ☐ No

If **yes**, what type of Prion Disease?

☐ CJD
☐ GSS
☐ FFI
☐ Other: _____

Name: _____

Relationship to patient: _____

Neurological Diseases in Family

Is there a Family History of Neurological Disease? ☐ Yes ☐ No

If **yes**, what type of Disease?

☐ Alzheimer's
☐ Other:

Relationship to patient:

Social History

Hunting

Has patient ever hunted? ☐ Yes ☐ No

Hunted game:
☐ Deer
☐ Elk
☐ Moose
☐ Caribou
☐ Other

State/Province: _____

Hunting Year(s): _____

Consumption

Has patient ever consumed venison? ☐ Yes ☐ No

Consumed game:
☐ Deer
☐ Elk
☐ Moose
☐ Caribou
☐ Other

State/Province: _____

Consumption Year(s): _____

Travel

Has patient ever travelled to UK, Europe, or Saudi Arabia between years 1980-1996? ☐ Yes ☐ No

Countries: _____

Year(s): _____

Contact and Mailing Address:

NPDPSC Institute of Pathology, CWRU
2085 Adelbert Rd, Room 414
Cleveland, Ohio, 44106-4907

Phone: 216-368-0587
Fax: 216-368-4090
Email: cjdsurveillance@uhhospitals.org