

This requisition form, when completed, constitutes a referral to the BC Neuroimmunology Laboratory 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		FIRST NAME & MIDDLE INITIAL		PHYSICIAN NAME & MSP PRACTITIONER # (IF APPLICABLE)		
PROVINCIAL HEALTHCARE NUMBER (e.g. PHN, OHIP)		DATE OF BIRTH (MONTH/DAY/YEAR)		SEX		ADDRESS
ADDRESS		CITY/TOWN		<input type="checkbox"/> M <input type="checkbox"/> F		
PROVINCE		POSTAL CODE		TELEPHONE #		TELEPHONE (REQUIRED FOR STAT TESTS)
DIAGNOSIS AND INDICATIONS FOR TESTING AND/OR SPECIAL TREATMENTS (e.g. patient on IVIG)			FACSIMILE (REQUIRED FOR STAT TESTS)			
BILL TO			COPY TO PHYSICIAN(S)			
<input type="checkbox"/> Provincial Health Services <input type="checkbox"/> Hospital (Inpatients) <input type="checkbox"/> Patient* (Self-pay; see below) <input type="checkbox"/> Other:						
REQUESTING LABORATORY			SPECIMEN INFORMATION			
LABORATORY/FACILITY NAME			SPECIMEN TYPE			
ADDRESS			<input type="checkbox"/> Serum <input type="checkbox"/> CSF			
CITY/TOWN			COLLECTION DATE (MONTH/DAY/YEAR)			
PROVINCE			MONTH			
TELEPHONE (REQUIRED FOR STAT TESTS)			DAY			
FACSIMILE (REQUIRED FOR STAT TESTS)			YEAR			
REFERRED LABORATORY TESTS		ALL TESTS, EXCEPT 'ACHR AB ONLY', MUST BE ORDERED BY A NEUROLOGIST		^ TESTS BILLABLE TO PROVINCIAL HEALTH SERVICES. Contact us for pricing information of other tests (see Self-pay below).		
MYASTHENIA GRAVIS		AUTOIMMUNE ENCEPHALITIS		MULTIPLE SCLEROSIS		
<input type="checkbox"/> Acetylcholine receptor (AChR) antibodies (Ab) by RIPA <u>only</u> (g1020/g1021)^ <input type="checkbox"/> Muscle-specific Tyrosine Kinase (MuSK) Ab <u>only</u> (P91022)^ <input type="checkbox"/> AChR Ab with reflex MuSK Ab testing <input type="checkbox"/> Antibodies to clustered AChR Ab by live CBA <input type="checkbox"/> Low-density lipoprotein receptor-related protein 4 (LRP4) Ab by live CBA [RESEARCH PURPOSES ONLY]		<input type="checkbox"/> NMDAR Ab (STAT test) <input type="checkbox"/> GABA _B Ab <input type="checkbox"/> Voltage-gated potassium channel (VGKC) associated protein (LGI ₁ & CASPR ₂) Ab <input type="checkbox"/> Anti-DPPX Ab <input type="checkbox"/> MOSAIC-6 Autoimmune Encephalitis Panel [NMDAR, GABA _B , LGI ₁ , CASPR ₂ , AMPAR Ab]		<input type="checkbox"/> Neutralizing Abs to IFN-β (g1858)^ Required information: Current IFN-β treatment: <input type="checkbox"/> Rebif22 <input type="checkbox"/> Rebif44 <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron On IFN-β Since (Date): _____ Previous IFN-β treatment: <input type="checkbox"/> Rebif22 <input type="checkbox"/> Rebif44 <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron On IFN-β From (Date): _____ To (Date): _____		
NEUROMYELITIS OPTICA		PARANEOPLASTIC NEUROLOGICAL SYNDROME				
<input type="checkbox"/> Aquaporin-4 (AQP4) Ab <input type="checkbox"/> Myelin oligodendrocyte glycoprotein (MOG) Ab		<input type="checkbox"/> PNS Ab Panel [Amphiphysin, CV2 (CRMP5), PNMA2 (Maz/Ta), Ri, Yo, Hu, Recoverin, SOX1, Titin, Zic4, GAD65, Tr(DNER)]				
LAMBERT-EATON MYASTHENIC SYNDROME		CHRONIC INFLAMMATORY DEMYELINATING NEUROPATHY				
<input type="checkbox"/> Voltage-gated calcium channel (VGCC) Ab (P91861)^		<input type="checkbox"/> Test Panel – Nodal & Paranodal Abs (NF140, NF155, NF186, CNTN1, CASPR1)				
OTHER/COMMENTS:						
REFERRING PHYSICIAN SIGNATURE						
SIGNATURE OF REFERRING PHYSICIAN			MONTH			
			DAY			
			YEAR			
SPECIMEN COLLECTION			SHIPPING & DELIVERY INSTRUCTIONS			
LABEL ALL SPECIMENS WITH PATIENT'S FULL NAME, DOB, AND/OR HEALTH CARD NUMBER, AND COLLECTION DATE SERUM: Draw blood in two or more tubes with SST activator enough for 2-5 ml serum. Spin tubes, pool serum, freeze if being stored for >1 week, then batch for delivery on ice packs. We will reject samples that are grossly lipemic, hemolyzed, or icteric. CSF: Collect at least 2ml (2cc) CSF into a sterile tube. Deliver as soon as possible on ice packs.			<ul style="list-style-type: none"> • Packages should include labelled samples and completed and signed requisition forms. Samples should be shipped in accordance to IATA, ICAO, and TDG regulations. • No weekend and statutory holiday deliveries • Delivery Address: BC Neuroimmunology Laboratory Room S-157, 2211 Wesbrook Mall Vancouver, BC V6T 2B5 Telephone: 604-822-7175 			
*PATIENT SELF-PAY			**MuSK ANTIBODY TESTING MSC GUIDELINES			
For patient self-pay samples to be processed by the lab, all requested self-pay tests must be PRE-PAID . Tests can be paid for by credit card or cheque. Contact us for pricing information of individual tests. Please contact the laboratory at 604-822-7175 or info@bcneuro.ca for more information.			As per the Medical Services Commission of BC (MSC), for MuSK antibody testing to be covered by provincial health services, the test can only be requested by neurologists or ophthalmologists and can only be performed on a patient that has tested negative for acetylcholine receptor antibodies (AChR Ab) within the last 18 months. Repeat testing in 3-6 months may be done in patients with previous "borderline" results. However, repeat testing in negative patients is not indicated.			
<small>The personal information collected on this form and any medical data subsequently developed will be used and disclosed only as permitted or required by the Personal Information Act. The BC Neuroimmunology Laboratory Inc. privacy statement is available on our website (http://bcneuro.ca). Use of this form implies consent for the use of de-identified patient data and specimens for quality assurance purposes.</small>						