

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. Please see page 2 for specimen collection and shipping instructions, as well as information regarding private payment, test specific MSP guidelines, and the test directory. *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 (DAY/MONTH/YEAR)	ADDRESS		
PATIENT TYPE <input type="checkbox"/> Out-Patient <input type="checkbox"/> In-Patient or Emergency		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X <input type="checkbox"/> Unknown	DAY MONTH YEAR		
ADDRESS		CITY/TOWN	TELEPHONE (REQUIRED FOR STAT TESTS)		FACSIMILE (REQUIRED FOR STAT TESTS)
PROVINCE		POSTAL CODE	TELEPHONE # (REQUIRED FOR STAT TESTS)		
BILL TO <input type="checkbox"/> Provincial Health Services <input type="checkbox"/> Hospital <input type="checkbox"/> Patient ¹ (Self-pay; see page 2) <input type="checkbox"/> Other: _____			COPY TO PHYSICIAN(S)		
REQUESTING LABORATORY:			SPECIMEN INFORMATION		
LABORATORY/FACILITY NAME			SPECIMEN TYPE <input type="checkbox"/> Serum <input type="checkbox"/> CSF <input type="checkbox"/> Plasma		
ADDRESS		CITY/TOWN	SPECIMEN NO.:		
TELEPHONE (REQUIRED FOR STAT TESTS)		FACSIMILE (REQUIRED FOR STAT TESTS)	COLLECTION DATE (DAY/MONTH/YEAR)		
			DAY	MONTH	YEAR

REFERRED LABORATORY TESTS		
ALL TESTS ARE ON A PRIVATE PAYMENT ¹ BASIS (SEE PAGE 2) UNLESS OTHERWISE STATED. FOR TEST-SPECIFIC INFORMATION, PLEASE REFER TO OUR TEST DIRECTORY ² (SEE PAGE 2).		
Myasthenia Gravis <input type="checkbox"/> Acetylcholine receptor (AChR) antibodies (Ab) <u>only</u> (91020/91021) MSP Billable <input type="checkbox"/> Muscle-specific Tyrosine Kinase (MuSK) Ab <u>only</u> (P91022) MSP Billable³ (See page 2) <input type="checkbox"/> AChR Ab <u>with reflex</u> to MuSK Ab testing <input type="checkbox"/> Clustered AChR Ab live cell-based assay (CBA) <input type="checkbox"/> Low-density lipoprotein receptor-related protein 4 (LRP4) Ab CBA Required clinical information (please check all that apply): Diagnosis of MG: <input type="checkbox"/> Suspected <input type="checkbox"/> Established <input type="checkbox"/> MG Crisis <input type="checkbox"/> Clinical Remission Type of MG: <input type="checkbox"/> Ocular <input type="checkbox"/> Bulbar <input type="checkbox"/> Generalized Criteria for Diagnosis: <input type="checkbox"/> Repeated Stimulation (RNS) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown <input type="checkbox"/> Increased jitter (SFEMG) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown Additional clinical info., Immunomodulatory drugs given and response: _____ _____	Chronic Inflammatory Demyelinating Neuropathy <input type="checkbox"/> CIDP Panel – 5 Nodal & Paranodal antibodies – CASPR1, CNTN1, NF186, NF140, NF155 Clinical Information (please check all that apply): <input type="checkbox"/> Gradual onset (> 3 month) <input type="checkbox"/> Rapid onset (≤ one month) <input type="checkbox"/> Pain <input type="checkbox"/> Abnormal sensation <input type="checkbox"/> Sensory loss <input type="checkbox"/> Weakness or fatigue <input type="checkbox"/> Muscles atrophy <input type="checkbox"/> Loss of reflexes <input type="checkbox"/> Double vision <input type="checkbox"/> Difficulty swallowing	Neuromyelitis Optica Spectrum Disorder <input type="checkbox"/> Aquaporin-4 (AQP4) Ab live CBA <input type="checkbox"/> Myelin oligodendrocyte glycoprotein (MOG) Ab live CBA Clinical Information (please check all that apply): <input type="checkbox"/> ADEM <input type="checkbox"/> MDEM <input type="checkbox"/> ADEM-ON <input type="checkbox"/> Optic neuritis <input type="checkbox"/> Transverse Myelitis <input type="checkbox"/> Area Postrema Syndrome <input type="checkbox"/> Acute Brainstem Syndrome <input type="checkbox"/> Symptomatic Cerebral Syndrome <input type="checkbox"/> Symptomatic Narcolepsy <input type="checkbox"/> Acute Diencephalic Clinical Syndrome
Autoimmune Encephalitis & Paraneoplastic Neurologic Syndrome		
Lambert-Eaton Myasthenic Syndrome <input type="checkbox"/> Voltage-gated calcium channel (VGCC) Ab (P91861) MSP Billable³ (See page 2) Clinical Information (please check all that apply): <input type="checkbox"/> Proximal weakness <input type="checkbox"/> Cognitive changes <input type="checkbox"/> Reduced deep tendon reflexes <input type="checkbox"/> Myelitis <input type="checkbox"/> Autonomic dysfunction <input type="checkbox"/> Cerebellar ataxia <input type="checkbox"/> Dysmetria	<input type="checkbox"/> Preliminary Testing Panel for Autoimmune Encephalitis NMDAR, GABAB, LGI1, CASPR2, DPPX, AMPAR (All positives reflex to tissue-based assay) Notes : For STAT orders (~24-hour TAT), please indicate or call lab at 604-822-7175 _____ <input type="checkbox"/> Preliminary Testing Panel for Paraneoplastic Antibodies Amphiphysin, CV2, PNMA2, Ri, Yo, Hu, Recoverin, SOX1, Titin, Zic4, GAD65, Tr (DNER) (All positives reflex to tissue-based assay) <input type="checkbox"/> Comprehensive in-house Testing Panel (This test should be ordered for patients with high clinical suspicion and negative results from preliminary panels) NMDAR, GABAB, LGI1, CASPR2, DPPX, AMPAR, Amphiphysin, CV2, PNMA2, Ri, Yo, Hu, Recoverin, SOX1, Titin, Zic4, GAD65, Tr (DNER), GluR1, GluR5, GlyR, KLH11, GFAP, and IgLON5 (Screening with Euroimmun mosaic/paraneoplastic/immunoblot/in-house rat-brain immunohistochemistry /immunofluorescence reflex to in-house CBAs) Individual Antibody Testing (Mosaic/in-house CBAs; all positives reflex to a tissue-based assay) <input type="checkbox"/> NMDAR STAT (CSF only) <input type="checkbox"/> LGI1 & CASPR2 <input type="checkbox"/> AMPAR <input type="checkbox"/> GABAB <input type="checkbox"/> DPPX <input type="checkbox"/> GAD65 <input type="checkbox"/> IgLON5 <input type="checkbox"/> GFAP	Clinical Information (please fill and check all that apply): Date of illness onset: _____ Clinical Suspicion: <input type="checkbox"/> High <input type="checkbox"/> Intermediate <input type="checkbox"/> Low Family history of autoimmunity: <input type="checkbox"/> Yes <input type="checkbox"/> No Neurologic/Psychiatric change: <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of cancer: _____ Prodromal symptoms: <input type="checkbox"/> Flu-like symptoms <input type="checkbox"/> Diarrhea <input type="checkbox"/> Weight loss <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Sleep disturbances Clinical Phenotype: <input type="checkbox"/> Encephalomyelitis <input type="checkbox"/> LE <input type="checkbox"/> OMS <input type="checkbox"/> Stiff-person syndrome <input type="checkbox"/> Rapidly progressive cerebellar syndrome <input type="checkbox"/> Sensory neuropathy <input type="checkbox"/> Morvan syndrome Immunomodulatory drugs given & response: _____ _____
OTHER COMMENTS (diagnosis and/or special treatments - e.g., patient on IVIG):		

REFERRING PHYSICIAN SIGNATURE	
NAME & SIGNATURE OF REFERRING PHYSICIAN	DATE
	DAY MONTH YEAR

SPECIMEN COLLECTION

- No patient preparation is required for sample collection.
- Blood collection tubes:
 - For **serum**, use gold-top SST vacutainer tubes
 - For **plasma**, use K2 EDTA lavender-top vacutainer tubes.
- Draw blood in collection tube(s) enough for a total of 1 to 5 ml serum or plasma. Spin collection tubes, pool serum or plasma (if necessary), freeze, then batch for shipping on ice packs or dry ice as appropriate for the test(s) requested (see **Test Directory**² below).
- **CSF**: Collect at least 3-5 ml (3-5 cc) CSF into a sterile tube. Deliver as soon as possible on ice packs.
- LABEL ALL SPECIMENS WITH PATIENT'S FULL NAME, DOB, AND SAMPLE COLLECTION DATE

SHIPPING & DELIVERY INSTRUCTIONS

- 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 Inc.**
Room S-157, 2211 Wesbrook Mall
Vancouver, BC V6T 2B5
Telephone: 604-822-7175

¹ PRIVATE PAYMENT

- Tests that are offered on a "private payment" basis can be paid by the requesting laboratory or the patient ("*Self-Pay*").
- For patients, all requested self-pay tests must be **PRE-PAID**, before samples can be processed by BC Neuroimmunology Laboratory Inc. Tests can be paid for by personal credit card or cheque. Please contact us at accounting@bcneuro.ca to pre-pay tests.
 - For laboratories, please contact us for your payment options of invoices or email accounting@bcneuro.ca for more information.

² TEST DIRECTORY

For test-specific information, such as methodology, sample handling and stability, minimum volume, turnaround time, testing frequency, and terms of coverage under the BC Medical Services Plan, please see our [test directory](https://bcneuro.ca/tests/), which can be found on our website (<https://bcneuro.ca/tests/>).

³ MSP Guidelines for MuSK Ab and VGCC Ab Testing within British Columbia

As per the Medical Services Plan of BC (MSP), for MuSK and VGCC antibody testing to be covered by provincial health services, testing *must* be requested by a **neurologist** or, for MuSK Ab, an **ophthalmologist** or **neuro-ophthalmologist**. Otherwise, testing can be ordered on a private-pay¹ basis (*see above*).

For MuSK Ab Testing, the patient *must* have been found AchR Ab negative within the last 18 months with BC Neuroimmunology or with another laboratory, in which case, a copy of the results from the other laboratory must be attached or stated on the requisition by the ordering physician. MuSK Ab testing can be re-ordered for patients whose previous MuSK Ab results in Borderline or Positive, within 3-6 months of the previous test date. MSP does **not** cover repeat testing for patients previously negative for MuSK Ab. However, in the event that a patient's symptoms are significantly progressing, and repeat MuSK Ab testing is needed, please contact the laboratory for arrangements.

For VGCC Ab Testing, MSP does **not** cover repeat testing under any circumstances, as it is a once-in-a-lifetime test. Any additional testing *must* be ordered on a private-pay¹ basis.

DAP ISO 15189 ACCREDITATION

This facility has successfully met the accreditation requirements of the College of Physicians and Surgeons of BC Diagnostic Accreditation Program standards and been granted the internationally recognized DAP ISO 15189 accreditation award.

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.