

This area is for BC Neuroimmunology Laboratory use only.

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	
PROVINCIAL HEALTHCARE NUMBER (e.g. PHN, OHIP)		DATE OF BIRTH (DAY/MONTH/YEAR)	
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	
ADDRESS		CITY/TOWN	
PROVINCE		POSTAL CODE	
BILL TO		TELEPHONE # & EMAIL (REQUIRED FOR PAYMENT)	
<input type="checkbox"/> Provincial Health Services <input type="checkbox"/> Hospital <input type="checkbox"/> Patient <sup>1</sup> (Self-pay; see page 2) <input type="checkbox"/> Other: _____		TELEPHONE (REQUIRED FOR STAT TESTS)    FACSIMILE (REQUIRED FOR STAT TESTS)	
REQUESTING LABORATORY:		SPECIMEN INFORMATION	
LABORATORY/FACILITY NAME		SPECIMEN TYPE <input type="checkbox"/> Plasma <input type="checkbox"/> CSF	
ADDRESS		SPECIMEN NO.:	
CITY/TOWN		Time of Sample collection _____ am _____ pm	
PROVINCE		COLLECTION DATE (DAY/MONTH/YEAR)	
TELEPHONE (REQUIRED FOR STAT TESTS)		FACSIMILE (REQUIRED FOR STAT TESTS)	

Alzheimer's Disease	Non-AD Neurodegenerative Diseases	APOE Genotyping
<b>Plasma</b> <input type="checkbox"/> pTau217 ALZpath/SIMOA® <input type="checkbox"/> pTau217 Lumipulse® <input type="checkbox"/> GFAP Lumipulse® <input type="checkbox"/> NfL Lumipulse®	<b>CSF</b> <input type="checkbox"/> Aβ42/40 <input type="checkbox"/> pTau181 <input type="checkbox"/> NfL <input type="checkbox"/> tTau <input type="checkbox"/> Neurogranin	<input type="checkbox"/> Whole blood
<b>Required clinical information (please check all that apply):</b> <b>Clinical features:</b> <input type="checkbox"/> Episodic Memory problems <input type="checkbox"/> Visuospatial Problems <input type="checkbox"/> Language problems <input type="checkbox"/> Articulation problems <input type="checkbox"/> Behavioral Changes <input type="checkbox"/> Executive dysfunction <input type="checkbox"/> REM sleep behaviour disorder <input type="checkbox"/> Extrapyrimalidal dysfunction/ Parkinsonism <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations		<b>Required clinical information (please check all that apply):</b> <b>Clinical Diagnosis:</b> <input type="checkbox"/> Frontotemporal Dementia <input type="checkbox"/> Amyotrophic lateral sclerosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Traumatic Brain Injury (TBI) <input type="checkbox"/> Chronic Traumatic Encephalopathy (CTE) <input type="checkbox"/> Atypical Parkinson Disease <input type="checkbox"/> Huntington Disease <input type="checkbox"/> Creutzfeldt-Jakob disease <input type="checkbox"/> Normal Pressure Hydrocephalus <input type="checkbox"/> HIV-associated neurocognitive impairment <input type="checkbox"/> Vascular Dementia <input type="checkbox"/> Dementia with Lewy Body <input type="checkbox"/> Parkinson Disease with Dementia <input type="checkbox"/> Parkinson disease <input type="checkbox"/> Corticobasal degeneration <input type="checkbox"/> Progressive supranuclear palsy <input type="checkbox"/> Multiple system atrophy <input type="checkbox"/> Spinal Muscular Atrophy
<b>Cognitive test function score at onset:</b> MMSE _____ MOCA _____ 3MS _____ Others(specify) _____  <b>Imaging Findings:</b> <b>MRI</b> <input type="checkbox"/> Normal <input type="checkbox"/> Hippocampal Atrophy <input type="checkbox"/> Ventricular Dilatation <input type="checkbox"/> Abnormal fMRI <input type="checkbox"/> Positive Aβ PET <input type="checkbox"/> Positive Tau PET <b>Clinical Diagnosis:</b> <input type="checkbox"/> Cognitively unimpaired <input type="checkbox"/> Subjective Cognitive Decline <input type="checkbox"/> Amnesic MCI <input type="checkbox"/> Non-Amnesic MCI <input type="checkbox"/> Atypical AD <input type="checkbox"/> PCA <input type="checkbox"/> Lv PPA <input type="checkbox"/> frontal AD <input type="checkbox"/> motor variant <input type="checkbox"/> AD		

**OTHER COMMENTS (other diagnosis and/or special treatments, e.g. patient on kidney function medicine, last dose on DD/MM/YYYY):**

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

## INSTRUCTIONS FOR SENDING SAMPLES

- It is the responsibility of the Customer/Sender to ensure sample handling, sample identification, packaging, transportation, and delivery.
- Samples must have clear labelling and must be sent together with a completed requisition form.
- The referring hospital/clinic and the physician's name and contact information must be filled in on the requisition form.
- The sample should not be hemolytic, lipemic or icteric.

## SPECIMEN COLLECTION

- No patient preparation is required for sample collection.
- Collection tubes:
  - For **plasma**, use K2 EDTA lavender-top vacutainer tubes.
    - Draw blood in collection tube(s) enough for a total of 2 to 5 mL plasma. Spin collection tubes, pool plasma (if necessary) and store refrigerated. Samples must be received at the laboratory within 48 hrs of collection and shipped on ice packs. If batch shipping, samples must be frozen and shipped on dry ice.
  - For **CSF**, use Sarstedt CSF Tube 63.614.625.
    - Collect CSF directly into two Sarstedt tubes and fill the tube 50% to 80% minimum. The specimen must not be aliquoted from a regular collection tube. Freeze immediately after aliquoting and avoid freeze-thaw cycles or multiple tube transfers. Package on dry ice for shipment.
  - For **APOE Genotyping** whole blood, use lavender-top (EDTA) tube (preferred), yellow-top (ACD) tube.
    - Draw blood in collection tube(s) enough for a minimum of 1 mL of blood. Package on ice pack for shipment.
    - Note: Minimum volume is 1 mL, but it does not allow for repeat testing.
- 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**

## <sup>1</sup> 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](mailto:accounting@bcneuro.ca) to pre-pay tests.
  - For laboratories, please contact us for your payment options of invoices or email [accounting@bcneuro.ca](mailto:accounting@bcneuro.ca) for more information.

## <sup>2</sup>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/>).

## 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.