



**Request form biological markers in CSF**

**Include this form with your samples when sending**

**IBB ref nr:**

**Demographic Patient Data** (If possible use printed label or write clearly)

Votre patient-hôpital réf. ....  
Nom / Prénoms ...../  
Date de naissance / sexe ...../  
Pays natal .....  
Adresse / numéro .....  
Code postal / Commune .....  
Pays .....

**Analyse demandé:**

- ELISA(€165):  $\beta$ -amyloid peptide ( $A\beta_{1-42}$ ), total tau-protein (tau), phospho-tau (P-tau<sub>181P</sub>)
- Immunoblot(€45): 14-3-3-protein

Je, soussigné(e), déclare avoir été informé explicitement du fait qu'un montant me sera facturé pour l'analyse du marqueur biologique (non-remboursable par l'INAMI - remboursement néanmoins prévu dans le cadre de certaines assurances hospitalisation)

Signature patient(e) et/ou délégué(e): .....

CSF samples for ELISA analyses to be sent to:

Ref. Centre for Biological Markers of Memory Disorders  
Prof. Dr. P.P. De Deyn & Prof. Dr. S. Engelborghs  
Universiteitsplein 1, Building T Room 5.20  
BE-2610 Antwerp, Belgium  
Tel. +32 3 820 23 94 (Prof. Dr. S. Engelborghs)  
Tel laboratory: +32 3 820 26 31 - Fax: +32 3 820 26 18

CSF samples for Immunoblot analyses to be sent to:

Laboratory of Neurobiology  
Prof. Dr. P. Cras  
Universiteitsplein 1, Building T Room 5.20  
BE-2610 Antwerp, Belgium  
Tel. +32 3 821 57 57 (Prof. Dr. P. Cras)  
Tel laboratory: +32 3 820 26 05 - Fax: +32 3 820 26 69

**Doctor info**

Doctor: .....  
RIZIV/INAMI nr: .....  
Hospital: .....  
Street: .....  
Postal code / city: .....  
Country .....

The patient has been informed that he/she will receive an invoice for the above-mentioned CSF biomarker analyses.

Signature /date .....

**Clinical diagnosis?**

.....  
.....  
Year of onset: .....  
MMSE: ...../30 points .....  
ADAS-cog: ...../70 points .....

**Please complete next page for 14-3-3 protein Immunoblot requests and add when sending the sample.**

Only for 14-3-3 protein Immunoblot requests. Add when sending the sample.

**Clinical symptoms**

	(please describe if present)			(please describe if present)			
	Yes	No		Yes	No		
Behavioural changes	<input type="checkbox"/>	<input type="checkbox"/>	.....	Falls	<input type="checkbox"/>	<input type="checkbox"/>	.....
Memory disturbances	<input type="checkbox"/>	<input type="checkbox"/>	.....	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	.....
Aphasia	<input type="checkbox"/>	<input type="checkbox"/>	.....	Myoclonus	<input type="checkbox"/>	<input type="checkbox"/>	.....
Apraxia	<input type="checkbox"/>	<input type="checkbox"/>	.....	Frontal signs	<input type="checkbox"/>	<input type="checkbox"/>	.....
Agnosia	<input type="checkbox"/>	<input type="checkbox"/>	.....	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>	.....
Dysarthria	<input type="checkbox"/>	<input type="checkbox"/>	.....	Disinhibition	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other cognitive signs	<input type="checkbox"/>	<input type="checkbox"/>	.....	Hyperorality	<input type="checkbox"/>	<input type="checkbox"/>	.....
Cerebellar signs	<input type="checkbox"/>	<input type="checkbox"/>	.....	Utilization behaviour	<input type="checkbox"/>	<input type="checkbox"/>	.....
Pyramidal signs	<input type="checkbox"/>	<input type="checkbox"/>	.....	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>	.....
Extra-pyramidal signs	<input type="checkbox"/>	<input type="checkbox"/>	.....	Other symptoms	<input type="checkbox"/>	<input type="checkbox"/>	.....
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	.....	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>	.....
Mutism	<input type="checkbox"/>	<input type="checkbox"/>	.....	Depression	<input type="checkbox"/>	<input type="checkbox"/>	.....
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	.....	Progressive dementia	<input type="checkbox"/>	<input type="checkbox"/>	.....
Parkinsonism	<input type="checkbox"/>	<input type="checkbox"/>	.....	Epilepsia	<input type="checkbox"/>	<input type="checkbox"/>	.....

**Neuro-imaging**

	Yes	No	
EEG	<input type="checkbox"/>	<input type="checkbox"/>	Result: .....
CT	<input type="checkbox"/>	<input type="checkbox"/>	Result: .....
MRI	<input type="checkbox"/>	<input type="checkbox"/>	Result: .....
SPECT	<input type="checkbox"/>	<input type="checkbox"/>	Result: .....

**Specific risk factors**

	Yes	No	Unknown	
Familial history of CJD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other dementia: .....
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quantity .....
Nicotine use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quantity .....
Ever had a residence in UK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When .....
Ever had a stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Year of stroke .....
Ever had an endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When / which hospital .....
Ever had surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery info .....
Ever had neurosurgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery hospital .....

**Recipient of human:**

	Yes	No	Unknown
Pituitary derived hormones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cornea transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recipient of transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole blood	.....		
Red blood cells	.....		
White blood cells	.....		
Platelets	.....		
Stable blood products (albumin, immunoglobulins, clotting factors)	.....		
Blood donor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical remarks:	.....		