



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)

Uw patiënt-ziekenhuis ref
Naam / Voornaam /
Geboortedatum / geslacht /
Straat / nr
Postcode / gemeente
Land

Aangevraagde analyse:

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

Ik, ondergetekende, verklaar duidelijk geïnformeerd te zijn rechtstreeks gefactureerd te worden voor de hierboven vermelde biomerker analyse (niet terugbetaalbaar door het RIZIV – terugbetaling wordt evenwel voorzien bij sommige supplementaire hospitalisatieverzekeringen).

Handtekening patiënt:

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 3 265 23 94 (Prof. Dr. S. Engelborghs)
Tel laboratory: +32 3 265 26 31 - Fax: +32 3 265 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 3 265 26 05 - Fax: +32 3 265 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

Date CSF sample:

Clinical diagnosis:

If applicable, tick one of the following boxes:

- Depression or psychiatric disorder *versus* dementia
- Mild Cognitive Impairment (MCI): increased risk of dementia?
- Alzheimer's Disease (AD) *versus* non-AD dementia
- Creutzfeldt-Jacob Disease (CJD) **Please also complete next page for 14-3-3 protein Immunoblot requests.**

MMSE:/30

Only for 14-3-3 protein Immunoblot requests.

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	Result:
EEG	<input type="checkbox"/>	<input type="checkbox"/>
CT	<input type="checkbox"/>	<input type="checkbox"/>
MRI	<input type="checkbox"/>	<input type="checkbox"/>
SPECT	<input type="checkbox"/>	<input type="checkbox"/>

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:		