PRION DISEASES SECTION REQUISITION FOR LABORATORY TESTING: CSF EP-QuIC TEST

Prion Diseases Section
National Microbiology Laboratory
1015 Arlington Street, Winnipeg, MB R3E 3R2
Telephone: (204) 789-6078 / Fax: (204) 789-5009
Email: CJD@phac-aspc.gc.ca

SENDER INFORMATION

INSTITUTION:

LABORATORY/DEPARTMENT:

ADDRESS:

CITY:

PROVINCE: POSTAL:

TELEPHONE: FAX:

EMAIL:

Note: Reports will be sent by fax to the number provided above.

PATIENT INFORMATION

NAME:

DATE OF BIRTH (YYYY-MM-DD):

SEX ◯ M ◯ F

CITY: PROVINCE:

SPECIMEN INFORMATION

SPECIMEN REF #:

COLLECTION DATE (YYYY-MM-DD):

Note: Minimum 1 mL required. Store and ship at -80°C. Sample must be non-xanthochromic and contain no visible blood.

TEST REQUESTED

☐ CSF EP-QuIC TEST

Accredited by the Standards Council of Canada to ISO/IEC 17025 (File no. 15734).

REFERRING PHYSICIAN

NAME:

ADDRESS:

CITY:

PROVINCE: POSTAL CODE:

TELEPHONE: FAX:

EMAIL:

CANADIAN CREUTZFELDT-JAKOB DISEASE SURVEILLANCE SYSTEM

Please be informed that by submitting this requisition patient information and test results will be shared with the CJD Surveillance System (CJDSS) who may contact the referring physician. Follow-up may occur following either positive or negative test results.

The National Microbiology Laboratory (NML) of the Public Health Agency of Canada (PHAC) provides reference diagnostic services free of charge. The Client and NML agree that this requisition acts as an agreement for the NML to provide testing, as described in the Guide to Services, for the above requested tests.

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RISK FACTORS FOR CJD (required)

MEDICAL AND SURGICAL PROCEDURES

Surgical Procedures

Has the patient had any of the following procedures? (check all that apply)

- ☐ NEUROSURGERY (YYYY-MM-DD): _____
- ☐ CORNEAL TRANSPLANT
- ☐ NONE

Medical Treatment

Has the patient received any of the following treatments? (check all that apply)

- ☐ PITUITARY GONADOTROPIN (cadaveric)
- ☐ HUMAN GROWTH HORMONE (cadaveric)
- ☐ NONE

SUPPORTIVE INVESTIGATIONS

Has the patient had an MRI suggestive of CJD?

- ☐ YES
- ☐ NO
- ☐ MRI not performed

Has the patient had an EEG with periodic SHARP wave complexes?

- ☐ YES
- ☐ NO
- ☐ EEG not performed

FAMILY HISTORY OF PRION DISEASE?

Does the patient have a family history of Prion disease (CJD, GSS, FFI)?

- ☐ YES
- ☐ NO

If yes, indicate type _____

Relation to relative (e.g., parent, sibling) _____

DISEASE INDICATIONS

DATE OF SYMPTOM ONSET (YYYY-MM): _____

Clinical Signs	present at onset	present to-date
DEMENTIA	☐	☐
ATAXIA	☐	☐
MYOCLONUS	☐	☐
VISUAL PROBLEMS (visual distortions, hallucinations, cortical blindness)	☐	☐
EXTRAPYRAMIDAL	☐	☐
PYRAMIDAL	☐	☐
PSYCHIATRIC	☐	☐
INSOMNIA	☐	☐

OTHER: _____

HISTORY OF HUNTING AND/OR CONSUMPTION OF GAME

Has the patient ever hunted?

- ☐ YES
- ☐ NO
- ☐ UNKNOWN

Does the patient regularly consume venison (deer, moose, elk, carbou)?

- ☐ YES
- ☐ NO
- ☐ UNKNOWN

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