Instituut BORN-BUNGE
Universiteit Antwerpen
www.bornbunge.be
IBB v.z.w.

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)

Your patient-hospital ref ……………………………….
Name/ First name ………………………………/……………………………………
Birth date/ Gender ………………………………/…………………………….……...
Street ………………………………………………………………….……...
Postal code / city ………………………………………………………………….…...
Country ………………………………………………………………….…...

Requested analyses:

☐ ELISA(€165): β-amyloid peptide ($Aβ_{1-42}$), total tau-protein (tau), phospho-tau ($P\text{-}tau_{181P}$)

☐ Immunoblot: (€45): 14-3-3-protein

I, undersigned, declare that I have been informed that I will receive an invoice for the above-mentioned CSF biomarker analyses (not covered by the regular Belgian insurance companies – refunding is however provided by some supplementary hospitalization insurances).

Patient signature:…………………………………………………………………………………………………..…

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

IBB ref nr: ____________

Only for 14-3-3 protein Immunoblot requests.

Clinical symptoms

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

Neuro-imaging

	Yes	No	
EEG	☐	☐	Result: ………………………………………………………………
CT	☐	☐	Result: ………………………………………………………………
MRI	☐	☐	Result: ………………………………………………………………
SPECT	☐	☐	Result: ………………………………………………………………

Specific risk factors

	Yes	No	Unknown		
Familial history of CJD	☐	☐	☐	Other dementia:	………………………………………
Alcohol use	☐	☐	☐	Quantity	………………………………………
Nicotine use	☐	☐	☐	Quantity	………………………………………
Ever had a residence in UK	☐	☐	☐	When	………………………………………
Ever had a stroke	☐	☐	☐	Year of stroke	………………………………………
Ever had an endoscopy	☐	☐	☐	When / which hospital	………………………………………
Ever had surgery	☐	☐	☐	Surgery info	………………………………………
Ever had neurosurgery	☐	☐	☐	Surgery hospital	………………………………………

Recipient of human:					Yes	No	Unknown
Pituitary derived hormones	☐	☐	☐	Dura mater graft	☐	☐	☐
Cornea transplant	☐	☐	☐	Xenografts	☐	☐	☐
Recipient of transfusion	☐	☐	☐				

Whole blood ……………………………………………………………………………………

Red blood cells ……………………………………………………………………………………

White blood cells ……………………………………………………………………………………

Platelets ……………………………………………………………………………………

Stable blood products (albumin, immunoglobulins, clotting factors) ……………………………………………

Blood donor ☐ ☐ ☐ When ……………………………………………………………

Clinical remarks: ……………………………………………………………………………………