



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:** (€165,00): **β-amyloid peptide (Aβ₁₋₄₂), total tau-protein (tau), phospho-tau (P-tau_{181P})**
- Immunoblot:** (€50,00): **14-3-3-protein**

Ik, ondergetekende, verklaar duidelijk geïnformeerd te zijn over de niet terugbetaalbare kostprijs van de hierboven vermelde biomarker analyses (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 Dementia (BIODEM)
Prof. Dr. S. Engelborghs
Universiteitsplein 1, Building T Room 6.31
BE-2610 Antwerp, Belgium
Tel. +32 3 265 25 96 (Prof. Dr. S. Engelborghs)
Tel laboratory: +32 3 265 26 31 - Fax: +32 3 265 26 69

CSF samples for **Immunoblot** analyses to be sent to:

Laboratory of Neurobiology
Prof. Dr. P. Cras
Universiteitsplein 1, Building T Room 6.31
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-Jakob Disease (CJD)

MMSE:/30

ADAS-cog:

Please include 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: |

Only for 14-3-3 protein Immunoblot requests.

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: | | | |