ST VINCENT'S HOSPITAL MELBOURNE

RCPA NATA

Accredited for compliance with NPAAC standards and ISO 15189

Accreditation No. 13786

Mitochondrial and Autoimmune Neurological Disorders Laboratory

5th Floor Daly Wing, St Vincent's Hospital
35 Victoria Pde, Fitzroy Victoria 3065
Tel: 03 9231 3366 Fax: 03 9231 3350

Office use only

SVR No. _____ Specimen No/s._____

Date: ____/____/____ Time_____:_____ Staff Member _____

Patient Information

Title | Surname | First Name | M/F | Date of Birth

Street | Suburb | State | Postcode

Country | Telephone No. | UR No.

Physician Information

Title | Surname | First Name | Provider No.

Hospital / Medical Centre/Clinic/Institution

Street | Suburb | State | Postcode

Country | Telephone No. / Fax No. | E-mail address

Specimen and Signed Consent for autoimmune testing

Note: Please request consent from patient/next of kin and indicate billing

> 60ul -1mls	> 60ul		
Blood Serum (SST II)	CSF	Date taken	Date Sent
Store at 4 C / Frozen			

Information obtained from these tests will be kept confidential and not released to anyone without prior patient permission. Does the patient consent to the testing of their serum and/or CSF? Yes No

Does the patient consent to the non-identified use of their specimen/s for test quality and validation activities and reports? Yes No

Signature.....
(Patient/Next of Kin)

Billing Information

Autoantibody tests *do not* attract a Medicare or Private Health Care Rebate
(Please note no Item numbers for rebates).

AUTOIMMUNE ENCEPHALITIS Includes: NMDA receptor VGKC-CASPR2 & LG1 proteins AMPA R1 & R2 receptor GABAB B1 & B2 receptor DPPX	$ 210 ☐	**Bill (Tick or cross one)** Hospital/MedicalCentre/ Institution ☐ Patient ☐

This form is not a referral slip for specimen collection. Laboratory scientist cannot collect specimens. Separate local pathology slips are to be completed for specimen collection. Patients must be referred to schedule appointments for the collection of cerebral spinal fluid (CSF). This form must accompany the specimen/s to the laboratory for testing

Name:

Clinical Features - Check Boxes

Presenting Complaint:

Age of onset:

Symptoms or Signs	Yes	No	N/A
Amnesia			
Confusion			
Seizures			
Myoclonus			
Movement disorder			
Dyskinesia			
Ataxia			
Sleep disorder			
Hallucinations			
Paranoia			
Pain			
Dysautonomia			
Hyponatraemia			
Hyperhidrosis			
Neuromytonia			
Myasthenia gravis			
Peripheral neuropathy			
Tumors			

Family History

Autosomal dominant ☐
Autosomal recessive ☐
Sporadic ☐
Other please specify:

Clinical Features - *Imaging Studies*	Norm	Abnorm	NA
MRI			
Medial temporal lobes			
Cerebral cortex			
Cerebellum			
Brainstem			
Basal Ganglia			

Laboratory Studies-	Yes	No	N/A
EEG			
Seizures			
Epileptiform discharges			
Diffuse slowing			
Focal slowing			
CSF analysis			
Elevated protein			
Lymphocystic Pleocytosis			
Other (eg. Biochemistry) please specify or attach report:			

Treatments	Yes	No	N/A
Antiepileptics Specify:			
Immunotherapy Specify:			
Other please specify or attach report:			