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

Accreditation No. 13786

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: Testing cannot proceed without a signed consent and billing details

10mls		150 uls			
Blood Serum (SST II or clot activator) Store at 4 C		**CSF**		**Date taken**	**Date Sent**

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 $ 125
Includes:
NMDA receptor
VGKC-CASPR2 & LG1 proteins
AMPA R1 & R2 receptor
GABAB B1 & B2 receptor
DPPX

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*	Check Boxes 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:			