


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

Patient Information				
Title	Surname	First Name	M/F	Date of Birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street		Suburb	State	Postcode
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Country	Telephone No.	UR No.		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Physician Information				
Title	Surname	First Name	Provider No.	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Hospital / Medical Centre/Clinic/Institution				
<input type="text"/>				
Street	Suburb	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Country	Telephone No. / Fax No.	E-mail address		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Specimen and Signed Consent for autoimmune testing				
Note: Please request consent from patient/next of kin and indicate <u>billing</u>				
<input type="checkbox"/> > 60ul -1mls		<input type="checkbox"/> > 60ul		<input type="text"/>
Blood Serum (SST II)		CSF		Date taken
<small>Store at 4 C / Frozen</small>				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				
<input type="checkbox"/> <input type="checkbox"/>				
Does the patient consent to the non-identified use of their specimen/s for test quality and validation activities and reports? Yes No				
<input type="checkbox"/> <input type="checkbox"/>				
 Signature				
(Patient/Next of Kin)				
Billing Information				
Autoantibody tests <u>do not</u> attract a Medicare or Private Health Care Rebate (Please note no Item numbers for rebates).				
AUTOIMMUNE ENCEPHALITIS \$ 240 <input type="checkbox"/>		Bill (Tick or cross one)		
Includes: NMDA receptor VGKC-CASPR2 & LG1 proteins AMPA R1 & R2 receptor GABAB B1 & B2 receptor DPPX		Hospital/MedicalCentre/ Institution <input type="checkbox"/>		
		Patient <input type="checkbox"/>		

Office use only			
SVR No.	Specimen No/s.		
Date: / /	Time: :	Staff Member	
Name:			
Clinical Features - Check Boxes			
Presenting Complaint:			
Age of onset:			
Symptoms or Signs	Yes	No	N/A
Amnesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myoclonus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyskinesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dysautonomia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyponatraemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperhidrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromytonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family History			
Autosomal dominant	<input type="checkbox"/>		
Autosomal recessive	<input type="checkbox"/>		
Sporadic	<input type="checkbox"/>		
Other please specify:			
Clinical Features -	Check Boxes		
Imaging Studies	Norm	Abnorm	NA
MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medial temporal lobes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cerebellum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brainstem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal Ganglia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory Studies-	Yes	No	N/A
EEG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epileptiform discharges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diffuse slowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Focal slowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CSF analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphocytic Pleocytosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (eg. Biochemistry) please specify or attach report:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Treatments	Yes	No	N/A
Antiepileptics Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunotherapy Specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other please specify or attach report:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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