National Prion Disease Pathology Surveillance Center

PRNP TEST REQUISITION FORM

NPDPSC Institute of Pathology, CWRU
2085 Adelbert Rd, Room 414
Cleveland, Ohio, 44106-4907

Phone: 216-368-0587
Fax: 216-368-2546
Email link: https://securemail.case.edu/encrypt
priondiagnostics@case.edu

Patient Information (required)

Patient ID (MRN#):		
Last Name:	First Name:	
Sex: ☐ Male ☐ Female	Date of Birth *(mm-dd-yyyy)*:	
Race:	Hispanic/Latino: ☐ Yes ☐ No	
Patient Address:		
City:	State:	Zip Code:

Ordering Provider (required)

Ordering Provider Name:		
Hospital/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number:	ICD-10 Diagnosis Code:	

* Fax number given must comply with applicable HIPAA regulations

Referring Laboratory

Contact Person:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:
NPI Number:	ICD-10 Diagnosis Code:	

Accounts Payable/Billing Information *(if applicable)*

☐ **Check here** if AP/Billing information is the same as Referring Laboratory. Otherwise, please fill out the information below.

Name:		
Laboratory/Institution:		
Phone:	Fax*:	
Street Address:		
City:	State:	Zip Code:

Primary Insurance Information *(if applicable)*

☐ **Check here** If we are to bill the patient directly.
Please fill out the information below and **include a copy of the front and back of the insurance card.**

Subscriber Name (if different than patient):		
Insurance Name:	Effective Date *(mm-dd-yyyy)*:	
Policy Number:	Group Number:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent ☐ Other:		
Insurance Company Address:		
City:	State:	Zip Code:

Whole Blood

***Must be accompanied by a signed Genetic Consent Form (page 2).**

☐ **Blood**
PRNP Gene Testing

Collection Date: _____ *(mm-dd-yyyy)* Volume: _____ mL

Preferred Container
Purple-top Tube (EDTA).
Shipping
Ship tubes at room temperature.

For shipping and contact information on clinical samples please visit
https://case.edu/medicine/pathology/divisions/national-prion-disease-pathology-surveillance-center/resources-professionals/contact-and-shipping-information

CASE WESTERN RESERVE UNIVERSITY
School of Medicine

NATIONAL PRION DISEASE PATHOLOGY SURVEILLANCE CENTER
10900 Euclid Ave., Cleveland, OH 44106
PHONE: 216.368.3611 EMAIL: pathology@case.edu

INFORMED CONSENT FOR GENETIC TESTING

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Genetic Sex

Patient's MRN | Ordering Provider's Name

Note to the Ordering Healthcare Provider:

Some states require that patients (or their authorized representatives) provide written informed consent before undergoing genetic testing. Additionally, the ordering healthcare provider must retain documentation of the informed consent within the patient's medical record. This form is designed to support the process of obtaining informed consent in compliance with applicable laws.

As the patient/patient's authorized representative, I understand the following and freely give my consent to this genetic testing:

GENERAL DESCRIPTION AND PURPOSE OF TEST

- My healthcare provider has recommended that I (or my child) receive the following genetic test: PRNP Genetic Testing (CPT 81404).
- My healthcare provider has explained that the purpose of this test is to look for mutations or genetic alterations known to be associated with the following: genetic prion diseases.
- I have reviewed information about this specific test and the relevant disease(s) tested for with my healthcare provider, and my healthcare provider has explained the test's risks and benefits. (Test-specific information is available on the NPDPSC website at https://case.edu/medicine/pathology/divisions/national-prion-disease-pathology-surveillance-center/clinical/blood-prnp-gene).

LIMITATIONS OF TEST

This test analyzes specific gene regions and does not rule out the possibility of an undetected variant in other gene regions. As in any laboratory test, there is a possibility of error.

AVAILABILITY OF GENETIC COUNSELING BEFORE AND AFTER TESTING

I have been provided with information about obtaining genetic counseling prior to giving my consent for this testing. I further understand that my healthcare provider may recommend consultation with a medical geneticist, genetic counselor and/or a physician after the testing is completed.

MEANING OF A POSITIVE TEST

A positive test result is an indication that I (or my child) may be predisposed to or have the specific disease(s) or condition(s) tested for. I may wish to consider further independent testing and/or to consult a physician or genetic counselor. I further understand that the ability of genetic testing to provide risk information and the level of certainty associated with a positive test result vary with the type of test.

MEANING OF A NEGATIVE TEST RESULT

A negative test result indicates that the clinically significant variant tested was not detected. Negative results may also be due to: (1) technical reasons (i.e., poor sample quality); and/or (2) the need to test other family members. I have discussed information about the detection rate for the disease(s)/ condition(s) with my healthcare provider and understand that a negative result does not guarantee that I (or my child) will not develop the disease/condition for which testing was performed.

DISCLOSURE OF TEST RESULTS

All tests are confidential and will be disclosed only to the ordering healthcare provider (or his or her designated representative) unless otherwise authorized by the patient in writing or required by law.

RETENTION OF SPECIMENS

No tests other than those authorized by my healthcare provider will be performed on my (or my child's) sample. Samples are deidentified after testing and retained in deidentified form for five years unless a shorter retention period is required by law.

Your signature below indicates that you understand to your satisfaction the information about the genetic testing ordered by your healthcare provider and that you consent to having this testing performed.

Signature of patient or date patients authorized representative | Date

Relationship to patient (if the patients authorized representative) | Date

Signature of healthcare provider | Date

Patient Information (required)

Patient ID (MRN#):	Date of Birth *(mm-dd-yyyy)*:
Last Name:	First Name:

Clinical, Family and Social History

To be completed by the requesting clinician. Also, please attach or send a clinician's assessment from the EMR.

Clinical Suspicion of Prion Disease

On a scale 1-10, with 1 being LOW and 10 being HIGH, what is the clinical suspicion of prion disease?

Please check one of the boxes:

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Clinical Symptoms

*Please indicate the symptom onset (mm/yyyy)

☐ Dementia: _____
☐ Ataxia: _____
☐ Myoclonus: _____
☐ Visual Changes: _____
☐ Extrapyramidal: _____
☐ Pyramidal: _____
☐ Psychiatric: _____
☐ Other: _____

Family History

CJD in Family

Is there a Family history of Prion Disease?
☐ Yes
☐ No

If **yes**, what type of Prion Disease?
☐ CJD
☐ GSS
☐ FFI
☐ Other: _____

Relationship to patient:

Neurological Diseases in Family

Is there a Family history of Neurological Disease?
☐ Yes
☐ No

If **yes**, what type of Disease?
☐ Alzheimer's
☐ Other: _____

Relationship to patient:

Social History

Hunting

Has patient ever **hunted** venison? ☐ Yes ☐ No

Venison Type: *(check all that apply)*
☐ Deer
☐ Elk
☐ Moose
☐ Caribou

State/Province:

Year(s):

Consumption

Has patient ever **consumed** venison? ☐ Yes ☐ No

Venison Type: *(check all that apply)*
☐ Deer
☐ Elk
☐ Moose
☐ Caribou

State/Province:

Year(s):

Travel

Has patient ever travelled to UK, Europe, or Saudi Arabia between years 1980-1996?
☐ Yes
☐ No

Countries:

Year(s):

Radiographic Findings

NPDPSC offers MRI interpretation at no cost. For assessment, please send brain MRI on disc to our mailing address.

Has patient had MRI suggestive of CJD?
☐ Yes
☐ No
☐ Not performed

Has patient had EEG with periodic sharp wave complexes?
☐ Yes
☐ No
☐ Not performed

Medical & Surgical History

RT-QuIC Results

Patient's RT-QuIC Results:
☐ Positive
☐ Negative
☐ Indeterminate
☐ Not Performed

Blood Transfusions

Has patient ever received blood?
☐ Yes
☐ No

Facility:

Year(s):

Surgical Procedures

Has the patient had any of these procedures?

Check all that apply:
☐ Neurosurgery
☐ Corneal transplant
☐ Dura mater graph
☐ None

Procedure facility: _____

Date: _____
(mm-dd-yyyy)

Medical Treatment

Has the patient had any of these treatments?

Check all that apply:
☐ Pituitary gonadotropin
☐ Human growth hormone
☐ None

Procedure facility: _____

Date: _____
(mm-dd-yyyy)