2405 Wesbrook Mall, room 5524
Vancouver BC
V6T 1Z3
www.neurocode.com

Epilepsy Test Requisition Form

Ordering Physician

Last Name | First Name | Billing #

Address

City | Province | Postal Code

Phone | Fax

Copy Physician/Genetic Counsellor | Billing #

Phone | Fax

Copy Physician/Genetic Counsellor | Billing #

Phone | Fax

Patient Information

Last Name | First and Middle Names

Date of Birth (DD/MMM/YYYY) | PHN

Gender

☐ Male ☐ Female ☐ Unknown

Address

City | Province | Postal Code

Ethnicity (check all that apply):

☐ African ☐ Ashkenazi ☐ Asian ☐ Caucasian ☐ Indigenous
☐ Hispanic ☐ Other, please specify:

Sample Type

☐ Whole Blood (in EDTA)
Adult: 3mL minimum
Pediatric: 1mL minimum
☐ Oral Rinse: 30mL minimum
☐ DNA – source:

Collection Details

Date Collected (DD/MMM/YYYY) | Collector's Initials

Time Collected (HH:MM)

COLLECTION LAB LABEL ONLY

Samples are NOT accepted if the answer to either question is "Yes":

- Has the patient had a blood transfusion within 2-4 weeks of specimen collection? ☐ Yes ☐ No
- Has the patient had an allogenic bone marrow transplant? ☐ Yes ☐ No

Test Selection

☐ Confirmatory Sanger sequencing validation

Neurocode Labs Use Only

Receiver's Name:

Receive Date (DD/MMM/YYYY):

Neurocode Labs Label

neurocode

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Variant(s) to Sanger sequence

HGNC gene symbol:	Genomic position (hg19):	Ref/Alt allele:
RefSeq ID:	HGVS* DNA change:	HGVS* protein change:
HGNC gene symbol:	Genomic position (hg19):	Ref/Alt allele:
RefSeq ID:	HGVS* DNA change:	HGVS* protein change:
HGNC gene symbol:	Genomic position (hg19):	Ref/Alt allele:
RefSeq ID:	HGVS* DNA change:	HGVS* protein change:
HGNC gene symbol:	Genomic position (hg19):	Ref/Alt allele:
RefSeq ID:	HGVS* DNA change:	HGVS* protein change:
HGNC gene symbol:	Genomic position (hg19):	Ref/Alt allele:
RefSeq ID:	HGVS* DNA change:	HGVS* protein change:

*http://varnomen.hgvs.org/recommendations/general/

Payment Information (required)

Name Address City Province/State Postal Code Country Phone	Contact Neurocode Labs, Inc. for pricing. □ Cheque or Bank Draft (make payable to Neurocode Labs, Inc.) in Canadian funds. □ Bank Transfer – please contact Neurocode Labs, Inc. for account information: accounting@neurocode.com

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Clinical History

☒ Epilepsy/Seizure Disorder

Seizure History

Age at first unprovoked seizure: _____months

Has this patient been diagnosed with an epilepsy syndrome? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Epileptic encephalopathy? ☐ Yes ☐ No ☐ Unknown

Developmental History ☐ N/A

Developmental delay? ☐ Yes ☐ No ☐ Unknown
If yes, preceding seizure onset? ☐ Yes ☐ No

Type of delay (choose all that apply):
- ☐ Gross/fine motor
- ☐ Speech/language
- ☐ Cognitive
- ☐ Adaptive
- ☐ Social Emotional
- ☐ Global

Regression or plateau? ☐ Yes ☐ No ☐ Unknown

Intellectual disability? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ *Mild ID*
☐ *Moderate ID*
☐ *Severe ID*

ADHD? ☐ Yes ☐ No ☐ Unknown

Autism spectrum disorder? ☐ Yes ☐ No ☐ Unknown

Neuropsychiatric comorbidity? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Neurological Exam ☐ N/A

Head circumference abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, ☐ *Microcephaly*
☐ *Macrocephaly*

Motor exam abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

EEG abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

MRI abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Visual / eye abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other Cranial Nerve abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other phenotypic abnormalities? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Describe Other Relevant Clinical Information ☐ N/A

History of an acquired brain injury? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other Medical Conditions? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Metabolic testing abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Single/Multi-gene testing abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Other genetic testing? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

Microarray abnormal? ☐ Yes ☐ No ☐ Unknown
If yes, please specify:

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Family History of Neurological Disorders

☐ No Known Family History
☐ Adopted

Relationship	Gender	Maternal	Paternal	Neurological Disorder	Age at Dx
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		
	☐M ☐F ☐UNK	☐	☐		

Other Relevant Family History

Physician's Statement and Signature

*This test is **medically necessary** for the risk assessment, diagnosis or detection of a disease, illness, impairment, symptom, syndrome or disorder. The results could direct medical management and treatment decisions. By my signature below, I indicate that I am the referring physician and/or authorized health care provider. I have explained the purpose, possible results (including incidental findings), and limitations of the test described above. The patient and/or patient's legal guardian has been given the opportunity to ask questions and/or seek genetic counseling. The patient, or the patient's legal guardian, has given informed consent for the test described above to be performed. By my signature below, I also indicate that the patient is eligible for testing (see page 4).*

Ordering Physician's Signature	Date (DD-MMM-YYYY)

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Requisition Instructions

Instructions for the proper completion of the test requisition can be found on our website at http://www.neurocode.com/tests.html, under the "Test Requisition Form" section.

If ordering physician is not a BC Children's Hospital pediatric neurologist, please contact Drs. Michelle Demos, Cyrus Boelman or Mary Connolly via paging at BC Children's Hospital (604-875-2161) for referral approval. Completed requisitions should be faxed to 604-875-2285 for referral approval signatures. "Neurocode Epilepsy Referral Approval" should appear in the fax subject line and return fax information is required.

Collection Instructions

Instructions for the proper collection of specimens can be found on our website at http://www.neurocode.com/tests.html, under the "Sending Samples" section. *Patients must visit a hospital or an out-patient facility operated by a health authority or hospital society for specimen collection.* The health authority or hospital society will pay the associated shipping and/or handling fees of the specimen for the approved test.

Shipping Instructions

Samples should be shipped according to IATA, ICAO and TDG regulations. ***All samples should be transported at room temperature and shipped on the same day or as soon as possible after sample collection/processing.*** If possible, samples should be collected Monday to Wednesday to ensure delivery to our facility before the weekend.

Sample handling/storage information prior to shipping:

Blood - samples can be stored at 4℃ (for no longer than 3-4 days) or at -20℃ for longer periods
Oral rinse – samples should be stored at 4℃ until ready for transport
DNA - should be stored at -20℃ until ready for transport

Packages should include:

1) Labelled sample(s) (with subject's initials, PHN and sample collection date)
2) The corresponding completed test requisition

Please note: samples that do not meet the requirements listed at http://www.neurocode.com/samples.html *will be rejected*. Incomplete test requisitions will result in testing delays, or possible sample rejection.

Ship samples to the following address:

Neurocode Labs, Inc.
Attn: Dr. Matthew Farrer
Room 5524, 2405 Wesbrook Mall
Vancouver, BC
Canada V6T 1Z3

If you have any questions regarding sample collection/processing and shipping, please contact us at info@neurocode.com.