



Cognitive Impairment Requisition

Highlighted fields must be filled. Failure to complete requisition will result in delayed results delivery.

For Neurocode Lab use only

Date Received: _____

Time Received: _____

Recipient: _____

This requisition form, when completed, constitutes a referral to the Neurocode USA Inc. It is for the use of authorized health care providers only.

PATIENT INFORMATION		REFERRING PHYSICIAN	
LAST NAME		PHYSICIAN NAME & NPI # (IF APPLICABLE)	
FIRST NAME		CLINIC / FACILITY NAME	
DATE OF BIRTH (MM/DD/YYYY)		ADDRESS CITY / STATE / ZIP	
SEX ☐ Male ☐ Female ☐ Other/Unknown		TELEPHONE NUMBER	
TELEPHONE NUMBER		RESULTS DELIVERY METHOD RESULTS ARE DELIVERED BY WEB PORTAL. PLEASE PROVIDE EMAIL FOR PORTAL ACCESS	
E-MAIL		Email: _____	
ADDRESS		ACKNOWLEDGEMENT: I hereby confirm that information has been provided to the patient about the test(s) to be performed and the patient has given consent as required under applicable laws and regulations for the test(s) to be performed. The test(s) to be performed are medically necessary and the results will be used for medical management and treatment decision purposes for this patient. I confirm that the person listed as the Ordering Clinician is authorized by law to order the test(s) requested herein.	
CITY / STATE / ZIP		REQUIRED ORDERING CLINICIAN SIGNATURE DATE (MM/DD/YY) X	
REFERRED LABORATORY TESTS (REQUIRED)			
NEURODEGENERATIVE DISORDERS (REQUIRED)			
Blood Tests ☐ Plasma p-tau 217 ☐ Plasma NF-L ☐ Plasma GFAP ☐ APOE proteotyping (RUO)			
PATIENT SIGNATURE X		DATE (MM/DD/YY)	
BILLING INFO			
☐ BILL CLINIC Clinic billing arrangement required			
CLIENT NAME			
CONTACT E-MAIL			
☐ BILL PATIENT Patient will be contacted to provide payment method.			
ADDITIONAL CLINICAL INFORMATION (please check):			
APOE: ☐ Unknown ☐ 2/2 ☐ 2/3 ☐ 2/4 ☐ 3/3 ☐ 3/4 ☐ 4/4			
Chronic Kidney Disease (CKD): ☐ Yes ☐ No ☐ Unknown			
Hypertension: ☐ Yes ☐ No ☐ Unknown			
Diabetes: ☐ Yes ☐ No ☐ Unknown			
History of cancer: ☐ Yes ☐ No ☐ Unknown			
History of stroke: ☐ Yes ☐ No ☐ Unknown			
History of myocardial infarction: ☐ Yes ☐ No ☐ Unknown			
REQUIRED DIAGNOSTIC INFORMATION (ICD-10) (Check all that apply)			
☐ G30.0 Alzheimer's disease with early onset ☐ G30.9 Alzheimer's disease, unspecified ☐ G31.0 Frontotemporal dementia ☐ 121 Myocardial Infarction			
☐ G30.1 Alzheimer's disease with late onset ☐ G35 Multiple Sclerosis ☐ G20 Parkinson's disease ☐ S06 Intracranial injury			
☐ G30.8 Other Alzheimer's disease ☐ G12.2.1 Amyotrophic lateral sclerosis ☐ 163 Cerebral infarction ☐ Other: _____			
(SECTION BELOW TO BE COMPLETED AT SAMPLE COLLECTION)			

REQUIRED SPECIMEN INFORMATION		
COLLECTION DATE (MM/DD/YY)	COLLECTION TIME (HH:MM) ☐ AM ☐ PM	SPECIMEN TYPE ☐ Plasma
COLLECTION LOCATION	COLLECTION PHONE	COLLECTION EMAIL

Label all specimens with patient full name, DOB, and sample collection date:
PLASMA: Draw blood in K2 EDTA for 2-5mL plasma. Spin tubes immediately (refrigerated preferred), aliquot plasma, store refrigerated (4°C). **Ship sample within 24 hours (if draw is Friday afternoon through Sunday, aliquot and refrigerate over the weekend; ship Monday morning).** Package on frozen cold packs for shipment.

SHIPPING & DELIVERY INSTRUCTIONS

- Package according to sample requirements. Send via Priority Overnight shipping.
 - Plasma should be shipped on cold packs within 24 hours of collection.
- Packages should include labelled samples (name and DOB) and completed and signed requisition forms. Samples should be shipped in accordance to IATA, ICAO, and FDA regulations.
- No weekend and statutory holiday deliveries (New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving, & Christmas).
- To ensure sample viability, all samples should be shipped Sunday-Thursday.
- Delivery Address: **ATTN: Neurocode**
3548 Meridian St, Suite 101
Bellingham, WA 98225
CustomerCare@neurocode.com