

Creutzfeldt-Jakob Disease

Requisition for 14-3-3 Testing of Cerebrospinal Fluid (CSF)

Patient Name	
Date of Birth	
Sex	
Date Sample Drawn	
Referring Physician	
Referring Physician Address	
Referring Institution	
Clinical Summary:	

Ship sample on dry ice Monday through Wednesday to :

Host Genetics and Prion Diseases
National Microbiology Laboratory, Health Canada
1015 Arlington Street
Winnipeg, Manitoba, R3E 3R2
Attention: D. Godal/ T.D. Airey
Phone: 204-789-6078 Fax: 204-789-5009

Your physician has requested that a laboratory test be performed on your behalf. When the test has been completed and your physician informed of the results, some of the original test sample may remain unused, and no longer be needed. These materials can play a very important role in research, and we ask that you consider donating them for this purpose.

I consent to the storage and use of unused materials for research purposes.

Name: _____ Date: _____

Witness: _____ Date: _____

I do not wish to donate unused materials for research purposes.