Neuro-Immunology Laboratories

Brain Research Centre

Acetylcholine Receptor Antibody Requisition

Please select: Quantitative ☐ or Qualitative ☐

PATIENT INFORMATION			
Personal Health Number	**Province**	**DOB (MM/DD/YYYY)**	
Surname of Patient	**First Name and Middle Initial**		**Gender (M/F)**
Address	**Tel (include area code)**		
City / Town	**Postal Code**		
Bill to: ☐ Prov. Health Services ☐ Hospital (In Patients) ☐ Patient ☐ Other _____			

REFERRING PHYSICIAN
Name of Physician / MSP Practitioner Number

Address

Telephone

Fax

Send Copy of Results to:

REQUESTING LABORATORY		
Facility		
Address	**Tel (include area code)**	**Fax (include area code)**
City/Town	**Province**	**Postal Code**

SPECIMEN INFORMATION

Date of Collection (MM/DD/YYYY)

Time of Collection (24h)

CLINICAL INFORMATION

1. ☐ **Diagnosis of M.G. is established** or ☐ **Diagnosis of M.G. suspected**
2. **Type of MG:** ☐ Acquired ☐ Congenital ☐ Neonatal (add mother's blood) ☐ Active
   ☐ Ocular ☐ Bulbar ☐ Generalized ☐ Clinical Remission
3. **Criteria for diagnosis**:

   Clinical: ☐ Diplopia ptosis ☐ Bulbar Sx ☐ Limb weak on exercise
   Electrical: ☐ Increased Jitter ☐ Decrement
   Pharmaco: ☐ Tensilon® test positive ☐ Effect of Mestinon®

4. **Osserman classification (modified)**

A	=	Remission
1	=	Ocular only
2A	=	Mild generalized
2B	=	Moderately severe generalized
3	=	Acute severe (respirator)
4	=	Chronic severe (respirator)

5. **Age:** _____ **Sex:** _____ **Duration of disease:** _____

PLEASE DRAW 1 TUBE, 2-5MLS WITH SST ACTIVATOR
SPIN, ALIQUOT SERUM, FREEZE & BATCH FOR DELIVERY
ON ICE PACKS (Dry Ice not necessary)

NO SATURDAY / SUNDAY DELIVERY

Dr. J Oger (604) 822 7548
Laboratory (604) 822 7175
Secretary/Billing (604) 822 7696
Facsimile (604) 822 0758

DELIVER TO
NEUROIMMUNOLOGY LABS
BRAIN RESEARCH CENTRE
UBC HOSPITAL, ROOM S157
2211 WESBROOK MALL
VANCOUVER BC V6T 2B5
ATTENTION TARIQ

Signature of Requesting Physician

Date (MM/DD/YYYY)

Version 1.0 April 6, 2010