



Neuro-Immunology Laboratories

Brain
Research
Centre



Acetylcholine Receptor Antibody Requisition

Please select: Quantitative or Qualitative

PATIENT INFORMATION			REFERRING PHYSICIAN	
Personal Health Number	Province	DOB (MM/DD/YYYY)	Name of Physician / MSP Practitioner Number	
Surname of Patient	First Name and Middle Initial	Gender (M/F)	Address	
Address	Tel (include area code)		Telephone	
City / Town	Postal Code		Fax	
Bill to: <input type="checkbox"/> Prov. Health Services <input type="checkbox"/> Hospital (In Patients) <input type="checkbox"/> Patient <input type="checkbox"/> Other _____			Send Copy of Results to:	
REQUESTING LABORATORY			SPECIMEN INFORMATION	
Facility			Date of Collection (MM/DD/YYYY)	
Address	Tel (include area code)	Fax (include area code)	Time of Collection (24h)	
City/Town	Province	Postal Code		
CLINICAL INFORMATION				
1. <input type="checkbox"/> Diagnosis of M.G. is established or <input type="checkbox"/> Diagnosis of M.G. suspected				
2. Type of MG: <input type="checkbox"/> Acquired <input type="checkbox"/> Congenital <input type="checkbox"/> Neonatal (add mother's blood) <input type="checkbox"/> Active <input type="checkbox"/> Ocular <input type="checkbox"/> Bulbar <input type="checkbox"/> Generalized <input type="checkbox"/> Clinical Remission				
3. Criteria for diagnosis:				
Clinical: <input type="checkbox"/> Diplopia ptosis		<input type="checkbox"/> Bulbar Sx		<input type="checkbox"/> Limb weak on exercise
Electrical: <input type="checkbox"/> Increased Jitter		<input type="checkbox"/> Decrement		
Pharmacology: <input type="checkbox"/> Tensilon® test positive		<input type="checkbox"/> 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)			DELIVER TO	
NO SATURDAY / SUNDAY DELIVERY			NEUROIMMUNOLOGY LABS BRAIN RESEARCH CENTRE UBC HOSPITAL, ROOM S157 2211 WESBROOK MALL VANCOUVER BC V6T 2B5 ATTENTION TARIQ	
Dr. J Oger (604) 822 7548 Laboratory (604) 822 7175 Secretary/Billing (604) 822 7696 Facsimile (604) 822 0758			Signature of Requesting Physician	
			Date (MM/DD/YYYY)	