

Diagnostic and Advisory Service for Neuromyelitis Optica



National Commissioning Group
for Highly Specialised Services

Oxford Referral Centre

Aquaporin-4 (NMO) antibody request form (NO CHARGE)

Please fill in all the fields and send with the sample to:

Immunology Department Churchill Hospital, Old Road, Headington, Oxford, OX3 7LJ	Fax number: 01865 225990
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Patient identification:

Physician:

Name:
DOB:
Gender: F <input type="checkbox"/> M <input type="checkbox"/>
Post code:

Consultant or GP:
Hospital or Medical Centre:
Address:
Telephone number:
Fax number:
Email:
PCT:

Clinical data:

Date of disease onset: _____ Date of current episode: _____

On immunosuppressive therapy: Yes No

Nearest clinical phenotype:

	<u>Monophasic</u>	<u>Relapsing</u>
Optic neuritis		
Transverse myelitis		
LETM (≥ 3 vertebral segments)		
NMO (ON+TM/LETM)		
ADEM		
MS (e.g. optico-spinal, severe ON, other)		
Other:		

<p>Other information or question:</p>
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Sample: serum CSF Date of sampling: _____

If sample test positive or patient has NMO, we will follow up the result with a questionnaire to allow us to audit the assay service.

For laboratory use only	
Lab number.....	Date received:
Result:	
Comments:	
Signature(s)	Date: