



NCRAD

Appendix C

CSF Sample and Shipment Notification Form

Please email or fax the form on or prior to the date of shipment.

To: Kelley Faber Email: alzstudy@iu.edu FAX: 317-321-2003 Phone: 1-800-526-2839

General Information:

From: _____ Date: _____

Phone: _____ Email: _____

Study: **PSDC** PIDN: _____

Sex: M F Year of Birth: _____

FedEx tracking #: _____

KIT BARCODE

CSF Collection:

1. Date of Collection: _____ 2. Time of Collection: 24 hour clock: _____ [HHMM]

3. Last date subject ate: _____ 4. Last time subject ate: 24 hour clock: _____ [HHMM]

5. Collection process: Gravity Method **OR** Aspiration

CSF Processing:

Time spin started: 24 hour clock: _____ [HHMM]

Duration of centrifuge: _____ minutes

Temp of centrifuge: _____ °C Rate of centrifuge: _____ x g

Total amount of CSF **collected** (ml): _____ ml

Time aliquoted: _____ [HHMM]

Number of 1.5 ml aliquots created (up to 16 total): **(Orange cap cryovials)**: _____ x 1.5 ml

If applicable, volume of CSF residual aliquot (less than 1.5 ml): **(Blue cap cryovial)**: _____ ml

If applicable, specimen number of residual aliquot tube: **(Last four digits)**: _____

Time frozen: _____ [HHMM]

Storage temperature of freezer: _____ °C

Notes: _____