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: 317-278-1100	Phone: 1-800-526-2839

From:__________________________________ **UPS tracking #:**_______________________________

Phone:__________________________________ **Email:**____

Site #:_________

Study: ALLFTD Longitudinal ☐ ALLFTD Biofluid ☐

RAVE ID: _________ **RAVE Cycle:** _______________

Kit #: KIT BARCODE

Sex: ☐ M ☐ F **Year of Birth:** _______________

CSF Collection:

1. Date of Draw: ____________________ [MMDDYY]	2. Time of Draw: __________________ [HHMM]
3. Date subject last ate: ______________ [MMDDYY]	4. Time subject last ate: ____________ [HHMM]
Collection Process: ☐ Gravitational **OR** ☐ Pull	

CSF Processing:

Time spin started:	____________ [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 CSF aliquots created (up to 15 total): **(Orange cap cryovials):**	____________
If applicable, volume of residual CSF aliquot (less than 1.5 mL): **(Blue cap cryovials):**	____________ mL
If applicable, specimen number of residual aliquot tube: **(Last four digits)**	____________
Time frozen:	____________ [HHMM]
Storage temperature of freezer:	____________°C

NOTES:

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