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

From:_____ **UPS tracking #:**_____

Phone:_____ **Email:**_____

PT ID: _____

BIFB ID: BIFB - ___ - ___ - _____

GUID: _____

Visit: Baseline **Sex:** ☐M ☐F **Year of Birth:** _____

KIT BARCODE

CSF Collection:

Date Drawn: _____	Time of Draw: _____ ☐AM ☐PM
Date subject last ate: _____	Time subject last ate: _____ ☐AM ☐PM
Collection process: ☐ Gravitational **OR** ☐ Pull	

CSF Processing:

Time spin started:	_____ ☐AM ☐PM
Duration of centrifuge:	_____ minutes
Temp of centrifuge:	_____ °C
Rate of centrifuge:	_____ x g
Total amount of CSF collected (mL):	_____ ml
Time aliquoted:	_____ ☐AM ☐PM
# of 1.5 mL CSF aliquots created: **(Clear-capped cryovial)**	_____
If applicable, volume of CSF residual aliquot (less than 1.5 mL): **(Blue-capped cryovial)**	_____ ml
If applicable, specimen number of residual aliquot tube: **(Last four digits)**	_____
Time frozen:	_____ ☐AM ☐PM
Storage temperature of freezer:	_____ °C

Notes: _____