

# Diagnostic and Advisory Service for Neuromyelitis Optica

**NMOUK**      Oxford Referral Centre



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

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

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

**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: <b>PCT:</b>
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**Clinical data:**

Date of disease onset: \_\_\_\_\_ Date of current episode: \_\_\_\_\_

On immunosuppressive therapy: Yes  No

**Nearest clinical phenotype:**

	<u>Monophasic</u>	<u>Relapsing</u>	<b>Other information or question:</b>
Optic neuritis			
Transverse myelitis			
LETM ( $\geq 3$ vertebral segments)			
NMO (ON+TM/LETM)			
ADEM			
MS (e.g. optico-spinal, bad ON, ...)			
Other:			

**Sample:** blood or 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 relevance of our assay.

**For laboratory use only**

Lab number..... Date received: .....

Result:

Comments:

Signature(s) \_\_\_\_\_ Date: \_\_\_\_\_