alzTEST

Test Requisition Form

Lykke Labs Inc.
Room 5105B – 2405 Wesbrook Mall
Vancouver BC V6T 1Z3
DAP: 0613LM

Ordering Physician

Last Name | First Name | Billing #

Address

City | Province | Postal Code

Phone | Fax

Email

Referring Physician Signature | Date (DD/MM/YYYY)

Copy Physician | Billing #

Phone | Fax

Patient Information

Last Name | First Name

Date of Birth (DD/MM/YYYY) | PHN

Sex

☐ Male ☐ Female

Address

City | Province | Postal Code

Risk Factor (check all that apply):

☐ COMM ☐ OBK ☐ SCHOOL ☐ HOSP ☐ CGT
☐ Other, please specify:

Specimen Information

☐ Whole Blood
Minimum Volume: 2 mL
Preferred Volume: 5 mL

☐ Plasma
Minimum Volume: 0.5 mL
Preferred Volume: 2 mL

☐ Saliva
Minimum Volume: 1.5 mL
Preferred Volume: 2 mL

☐ Other: Specify

Collection Details

Date Collected (DD/MM/YYYY)* | Sample Identifier*

Time Collected (HH:MM) | Collector's Initials

Priority: ☐Routine ☐Urgent ☐STAT

COLLECTION LAB LABEL ONLY

Samples are NOT accepted if the answer to either question is "Yes":

- Has the individual had a blood transfusion within 2-4 weeks of specimen collection? ☐ Yes ☐ No
- Has the individual had an allogenic bone marrow transplant? ☐ Yes ☐ No

Test Selection

Referred Laboratory Tests:

☐ APOE Genotyping ☐ p-Tau181 ☐ p-Tau217 ☐ Nf-L ☐ GenoRisk

Lab Use Only

Receiver's Name:

Receive Date (DD/MMM/YYYY):

*Please note that samples with incomplete or missing requisition forms will not be processed