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:

Name:

DOB:

Gender: F ☐ M ☐

Post code:

Physician:

Consultant or GP:

Hospital or Medical Centre:

Address:

Telephone number:
Fax number:
Email:
PCT:

Clinical data:
Date of disease onset: ________________ Date of current episode: __________________

On immunosuppressive therapy: Yes ☐ No ☐

Nearest clinical phenotype:

	Monophasic	Relapsing
Optic neuritis		
Transverse myelitis		
LETM (≥ 3 vertebral segments)		
NMO (ON+TM/LETM)		
ADEM		
MS (e.g. optico-spinal, bad ON, ...)		
Other:		

Other information or question:

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: