



## 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](mailto:alzstudy@iu.edu)    FAX: 317-278-1100    Phone: 1-800-526-2839

**General Information:**

**FedEx tracking #:** \_\_\_\_\_

From: \_\_\_\_\_ Site: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_ Date: \_\_\_\_\_

**Study:**  LEFFTDS     ARTFL     4RTNI-2  
 LEFFTDS and ARTFL

**Kit #:** \_\_\_\_\_  

KIT BARCODE

**Site ID:** \_\_\_\_\_    **RAVE #:** \_\_\_\_\_

**Fam #:** \_\_\_\_\_    **Sex:**  M  F    **Year of Birth:** \_\_\_\_\_    **Visit:** \_\_\_\_\_

**CSF Collection:**

1. Date of Collection: _____	2. Time of collection: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
3. Last time subject ate: Date: _____	4. Last time subject ate: Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
5. Collection process: <input type="checkbox"/> Gravitational <b>OR</b> <input type="checkbox"/> Pull	

**CSF Processing:**

1. Total number of CSF <b>aliquot</b> tubes: _____	4. Total number of CSF <b>0.5 mL aliquots</b> transferred to NCRAD: <b>(Clear cap cryovial):</b> _____
2. Total amount of CSF <b>collected</b> (mL): _____	5. Total number of CSF <b>1.0 mL aliquots</b> transferred to NCRAD: <b>(Orange cap cryovial):</b> _____
3. Time frozen: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	6. If applicable, volume of CSF residual aliquot (less than 0.5 mL): <b>(Blue cap cryovial):</b> _____
7. If applicable, specimen number of residual aliquot tube: <b>(Last four digits):</b> _____	

**Notes:** \_\_\_\_\_