



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: _____

Study: APOE Sex: M F Year of Birth: _____

APOE ID: _____

GUID: _____

PT ID: _____ N/A



CSF Collection:

| | |
|--|-------------------------------------|
| Date of Draw: _____ [MMDDYY] | Time of Draw: _____ [HHMM] |
| Date subject last ate: _____ [MMDDYY] | Time subject last ate: _____ [HHMM] |
| Collection process: <input type="checkbox"/> Gravitational OR <input type="checkbox"/> Pull | |

CSF Processing:

| |
|---|
| Time spin started: _____ [HHMM] |
| Duration of centrifuge: _____ minutes |
| Temp of centrifuge: _____ °C |
| Rate of centrifuge: _____ x g |
| Total amount of CSF collected (ml): _____ ml |
| Time aliquoted: _____ [HHMM] |
| # of 1.5 ml CSF aliquots created: (Orange-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: _____ [HHMM] |
| Storage temperature of freezer: _____ °C |

Notes: _____