

NIH Sample Identification Form: received (MVGS)

receipt date & MVGS# above for LMMN/NINDS/NIH use only

SAMPLES RECEIVED WITHOUT COMPLETED FORM BELOW WILL NOT BE PROCESSED

Test(s) to be performed: JC Virus: QPCR; ISH; ELISA; other(s) _____

Patient ID Number:	Institute/Hospital Name <i>(address optional):</i>
Patient Name (Initials):	
Patient Birth Date (dd- <u>MMM</u> -yyyy):	Institute/Hospital Contact <i>(other than Attending Phys):</i>
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Name: _____
	Email: _____
	Phone: _____ <i>(for international please include country code)</i>
Sample, volume, date collected (dd- <u>MMM</u> -yyyy):	Attending Physician's Address <i>(required hard-copy of results can only be sent to patient's Attending Physician; the Attending must request in writing for copies to be sent elsewhere):</i>
<input type="checkbox"/> CSF _____	
<input type="checkbox"/> Plasma _____	
<input type="checkbox"/> Serum _____	
<input type="checkbox"/> Urine _____	
<input type="checkbox"/> Biopsy (<i>tissue</i>) _____	
<input type="checkbox"/> Others _____ <i>(samples of the type "others" require prior approval)</i>	Results shipped by FedEx; P.O. Box addresses are not acceptable
Results Emailed (or faxed) to patient's Attending Physician only:	
Name: _____	
Email: _____ <i>(email required for notice of sample receipt & results reporting)</i>	
Phone: _____ <i>(phone necessary for mailing the required hard-copy of results)</i> <i>(for international please include country code)</i>	
Fax: _____ <i>(domestic-fax used only if email & mailing addresses are unsuitable to receive results...international-fax is problematic)</i> <i>(for international please include country code)</i>	

A brief summary of patient's current history *(if possible please include MS date of dx, other underlying disease with date of dx, MRI summary, cognitive & physical assessments, medications with time-frame & dosing, outcomes of any course-of-treatment, plans for medication/treatment, etc...):*

Underlying disease(s) and date(s) of diagnosis
Clinical symptoms presentation (cognitive and physical assessments)
Notes from MRI and other lab-test results (include dates)
Therapeutics administered including drug name(s), dosage(s), start/end date(s), and number of doses
Treatment plan(s)

Send samples by "Priority Overnight" to: Eugene O Major, PhD / National Institutes of Health / Laboratory of Molecular Medicine and Neuroscience / 10 Center Drive / Building 10, Room 3B14 / Bethesda, MD 20892-1296 // p.301.496.2899 / f.301.594.5799 // contacts: Peter Jensen p.301.496.2899 jensenp@ninds.nih.gov / Caroline Ryschkewitsch p.301.594.3305 ryschkec@ninds.nih.gov / Eugene O Major majorg@ninds.nih.gov