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

KIT BARCODE

CSF Collection:

Date of Draw: _____ [MMDDYY]	Time of Draw: _____ [HHMM]
Date participant last ate: _____ [MMDDYY]	Time participant last ate: _____ [HHMM]
Collection process: ☐ Gravitational **OR** ☐ 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: _____