

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: _____		
Site #: _____			
Study: ALLFTD Longitudinal Arm <input type="checkbox"/>	ALLFTD Biofluid-Focused Arm <input type="checkbox"/>	Kit #: _____ KIT BARCODE	
RAVE ID: _____	RAVE Cycle: _____		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Year of Birth: _____		
CSF Collection: (All Times Recorded using 24 hour clock: HHMM)			
1. Date of Draw: _____ [MMDDYY]		2. Time of Draw: _____ [HHMM]	
3. Date participant last ate: _____ [MMDDYY]		4. Time participant 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]	
Number of 1.5 mL CSF aliquots created (up to 15 total): (Orange cap cryovials):		_____	
If applicable, volume of residual CSF aliquot (less than 1.5 mL): (Blue cap cryovials):		_____ mL	
If applicable, specimen number of residual aliquot tube: (Last four digits)		_____	
Time frozen:		_____ [HHMM]	
Storage temperature of freezer:		_____ °C	
NOTES: _____ _____			