NEUROFILAMENT TEST REQUEST FORM

Forename
Surname
DOB
Gender
NHS No
Hospital No
Referring Consultant
Collection Date
Diagnosis
Current Treatment & Start Date
Last Relapse (DD/MM/YY)

Test Requested:

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CSF NfL</td>
<td></td>
</tr>
<tr>
<td>Serum NfL</td>
<td>(not currently available)</td>
</tr>
</tbody>
</table>

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We caution healthcare professionals in making any diagnoses or changes in management based on the information provided by the neurofilament test.