Email Form

AUTOIMMUNE ENCEPHALITIS PANEL QUESTIONNAIRE - COVER SHEET

****PLEASE PRINT PAGES OUT SINGLE-SIDED TO KEEP COVER SHEET SEPARATE FROM QUESTIONNAIRE****

Please fill in the following information and include this sheet with the clinical questionnaire when ordering the autoimmune encephalitis panel.

Patient Name (Last, First): _____

Patient date of birth (DD/MM/YYYY): _____

Patient PIN/MRN (if LHSC/SJHC patient): _____

Please send this cover sheet and clinical questionnaire with the collected serum and/or CSF sample, so that it can be processed by the LHSC immunology laboratory.
If you would like to fax this cover sheet and clinical questionnaire separately from the collected serum and/or CSF sample, **please fax to 519 663 3704.**

Please ensure a duplicate copy of this cover sheet and clinical questionnaire is kept in the patient chart, in case it needs to be re-sent for any reason.

If you have any questions regarding the collection/submission of the collected serum and/or CSF sample, please contact Dr. Liju Yang at 519 685 8500 ext. 35768.

Physician Information

Referring physician: **Date:**	**E-mail:** **Phone:**

Specimen Information

Sample Type: ☐Serum Sample collection date (DD/MM/YY):
☐CSF Sample collection date (DD/MM/YY):

Patient Demographic Information

Age:	Sex: ☐M ☐ F	Ethnicity:

Patient Clinical Information

Relevant past medical history: ☐Y ☐N ☐Thyroiditis ☐RA ☐Vitiligo ☐SLE ☐T1DM ☐Celiac disease ☐Sjogren's ☐Psoriasis Other: **Family history of autoimmunity:** ☐Y ☐N If yes, please specify:	**Neurologic/psychiatric history:** ☐ Y ☐N ☐Epilepsy ☐Migraine ☐Stroke ☐Multiple sclerosis ☐Depression ☐Anxiety ☐Psychotic illness Other:
Date of illness onset: **Illness duration:** **Prodromal symptoms (e.g. flu-like illness, headache, weight loss, diarrhea, etc):** **Preceding infection identified**:☐Y ☐N **If yes, please state which infection and how it was diagnosed (serology, PCR, etc):**	**Malignancy history**: ☐Y ☐N **Type of cancer**: **Stage of cancer**: **Time elapsed between malignancy diagnosis and presentation**: **Malignancy identified during work-up for neurologic presentation:** ☐Y ☐N **Test performed to diagnose malignancy (PET, CT, US, MRI etc):**

Patient Clinical Information Cont'd

Clinical course (please be sure to include patient symptomology, disease progression):

Modified Rankin score at time of sample collection (0-6):

Please list any immunomodulatory drugs given and any clinical response noted:

Patient Investigations

MRI performed: ☐Y ☐N **Gadolinium administered:** ☐Y☐N **Relevant abnormality seen:** ☐Y ☐N **If yes, please elaborate:**	**EEG performed:** ☐Y ☐N **Relevant abnormality seen:** ☐Y ☐N **If yes, please elaborate:**
Lumbar puncture performed: ☐Y ☐N **CSF WBC count elevated:** ☐Y ☐N **If yes, state WBC count and predominance (e.g. 60% lymphocytes):** **CSF protein elevated:** ☐Y ☐N **CSF/serum glucose <0.4:** ☐Y ☐N **Oligoclonal bands:** ☐Y ☐N ☐ Not sent	**EMG/NCS performed:** ☐Y ☐N **Polysomnography performed:** ☐Y ☐N **If relevant abnormality seen, please elaborate:**

Suspected Diagnosis

Pre-test probability that your patient's presentation is autoimmune (0-100%):

Suspected diagnosis:

☐Encephalitis
☐Brainstem encephalitis
☐Cerebellitis
☐Myelitis
☐Other (specify):

☐Stiff-person syndrome/PERM
☐Peripheral neuropathy
☐Peripheral nerve hyperexcitability
☐Epilepsy of unknown etiology

Patient Symptomatology Checklist

Behavioural/psychiatric change: ☐Y ☐N ☐Apathy ☐Depression ☐Disinhibition ☐Anxiety ☐Irritability ☐Psychosis Other:	**Cognitive dysfunction:** ☐Y ☐N ☐Memory loss ☐Aphasia ☐Executive dysfn ☐Visuospatial dysfn Other:
Seizures: ☐Y ☐N ☐Focal ☐Generalised ☐Status epilepticus Other (please classify seizures if present):	**Abnormal movements:** ☐Y ☐N ☐Chorea ☐Parkinsonism ☐Myoclonus ☐Dystonia ☐Tremor ☐Faciobrachial sz ☐Faciobrachial dystonic seizures Other:
Speech dysfunction: ☐Y ☐N ☐Expressive aphasia ☐Receptive aphasia ☐Speech apraxia ☐Pressured speech ☐Mutism ☐Dysarthria Other:	**Dysautonomia/hypoventilation:** ☐Y ☐N ☐Tachycardia/Bardycardia/arrhythmia ☐Hypertension/hypotension ☐Constipation/diarrhea ☐Urinary retention/incontinence ☐Pupillary mydriasis/miosis ☐Central hypoventilation ☐Hyperthermia/hypothermia Other:
Sleep disturbance: ☐Y ☐N ☐Insomnia ☐Hypersomnia ☐Obstructive sleep apnea ☐Central sleep apnea ☐REM sleep behaviour disorder Other:	**Motor/Sensory dysfunction:** ☐Y ☐N ☐Weakness ☐Sensory loss ☐Spasticity ☐Hypotonia ☐Hyperreflexia ☐Hyporeflexia ☐Atrophy ☐Fasiculations ☐Neuropathic pain ☐PNS Hyperexcitability Other:
Special sensory dysfunction: ☐Y ☐N ☐Pre-chiasmal visual loss ☐Chiasmal/post-chiasmal visual loss ☐Hearing loss (sensorineural/conductive) ☐Loss of smell ☐Loss of taste ☐Hallucination (visual/auditory/other) Other:	**Brainstem/cerebellar dysfunction:** ☐Y ☐N ☐Diplopia ☐Ophthalmoplegia ☐Facial nerve palsy ☐Trigeminal neuropathy ☐Dysarthria ☐Ataxia (Limb/Truncal) Other:

If able, please elaborate on any of the symptomatology identified above, or describe any other key symptoms not listed above: