

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. Please note, the clinical questionnaire is **required** for processing of 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. If you have any questions regarding the clinical questionnaire, please contact Dr. Adrian Budhram at 519 685 8500 ext. 17839.

Physician Information

Referring physician: Date:	E-mail: Phone:
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Specimen Information

Sample Type: <input type="checkbox"/> Serum Sample collection date (DD/MM/YY): <input type="checkbox"/> CSF Sample collection date (DD/MM/YY):
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Patient Demographic Information

Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity:
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Patient Clinical Information

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

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

Suspected Diagnosis

Pre-test probability that your patient's presentation is autoimmune (0-100%):
Check off which antibody/antibodies you are most suspecting (may check off more than one):

AMPAR GABA(B)R NMDAR LGI1 CASPR2 DPPX GAD IGLON5

Suspected diagnosis:

- | | |
|---|---|
| <input type="checkbox"/> Encephalitis
<input type="checkbox"/> Brainstem encephalitis
<input type="checkbox"/> Cerebellitis
<input type="checkbox"/> Myelitis
<input type="checkbox"/> Other (specify): | <input type="checkbox"/> Stiff-person syndrome/PERM
<input type="checkbox"/> Peripheral neuropathy
<input type="checkbox"/> Peripheral nerve hyperexcitability
<input type="checkbox"/> Epilepsy of unknown etiology |
|---|---|

Patient Symptomatology Checklist

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

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