



# SYN-ONE TEST™ REQUISITION FORM

CND Internal Use Only

Case #: \_\_\_\_\_

Date Received: \_\_\_\_\_

## Syn-One Test™ for Synucleinopathy

Syn-One is an anatomical pathology test to detect, visualize, and quantify the presence of abnormal, phosphorylated alpha-synuclein in cutaneous nerve fibers to support a diagnosis of a synucleinopathy: Parkinson's disease (PD), dementia with Lewy bodies (DLB), multiple system atrophy (MSA), pure autonomic failure (PAF), or REM sleep behavior disorder (RBD). Syn-One is also able to confirm and quantify the density of intra-epidermal nerve fibers to support a diagnosis of small fiber neuropathy and includes modified Congo red staining to identify amyloid proteins to support a diagnosis of amyloidosis.

Complete all the information below. **Sign and fax with the documents listed to (480) 569-2910:**

- Copy of patient's insurance card (front and back)
- Relevant medical records
- DaTscan
- Copy of patient's drivers license or state ID (front and back)
- Pathology report
- Other

## PATIENT INFORMATION

First Name  Middle Initial  Last Name / Surname

Date of Birth (Month/Day/Year)   Male  Female

ICD-10  G60.3 Idiopathic Neuropathy  G20 Parkinsonism  Other: \_\_\_\_\_

## PRACTICE INFORMATION

Ordering Physician/Clinician  Physician NPI (US) or Clinician ID Number (International)

Practice Name

Street Address  City  State

Zip or Postal Code  Country (International Only)

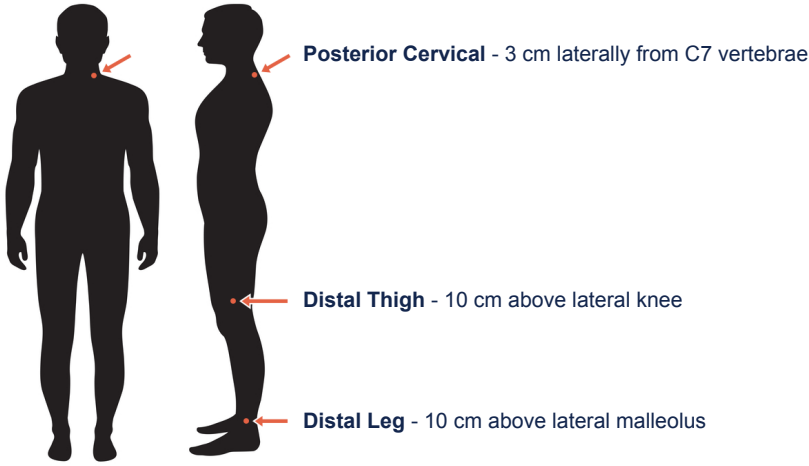
Phone Number  Fax Number  Email Address

## SYNUCLEINOPATHY CLINICAL INFORMATION

Family History of Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	REM Sleep Behavioral Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Response to L-Dopa <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Loss of Smell (Anosmia) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Response to Dopaminergic Agonists <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Periods of Confusion/Hallucinations <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Irregular Autonomic Function <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Bladder Dysfunction <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Resting Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	DaTScan Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Orthostatic Hypotension <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

**PLEASE COMPLETE AND SIGN THE OTHER SIDE OF THIS DOCUMENT**

## 3MM SKIN BIOPSY SPECIMEN INFORMATION



**Guidelines:**

- When performing the biopsy, the metal head of the punch tool should be used with gentle pressure and rotation until **fully into the skin**
- **Gently** handle the biopsy with the forceps
- Make sure the biopsy is **free floating** in the vial

Clinician Performing Biopsy

Physician NPI (US) or Clinician ID Number (International)

Date of Specimen (Month/Day/Year)

Time of Specimen   AM  PM

	Side (Choose One)	Location (Choose One)
<b>Specimen 1</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Posterior Cervical <input type="checkbox"/> Distal Thigh <input type="checkbox"/> Distal Leg <input type="checkbox"/> Other: _____
<b>Specimen 2</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Posterior Cervical <input type="checkbox"/> Distal Thigh <input type="checkbox"/> Distal Leg <input type="checkbox"/> Other: _____
<b>Specimen 3</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Posterior Cervical <input type="checkbox"/> Distal Thigh <input type="checkbox"/> Distal Leg <input type="checkbox"/> Other: _____

The undersigned certifies that he/she is licensed to order the test(s) selected and that such test(s) are medically necessary for the care/treatment of this patient

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

## SHIPPING INSTRUCTIONS

1. Label each vial with patient name, date, time, and body site.
2. Place this Requisition Form with supporting documentation and specimens into the insulated mailer and seal.
3. Place the sealed mailer into the FedEx UN 3373 Pak and seal.
4. Place the return label onto the return package in the designated area.
5. Contact **FedEx at 1 (800) 463-3339** to arrange same-day pickup with Next Day Delivery