North York General Hospital

Embracing Health

PRENATAL SCREENING for Down syndrome, Trisomy 18 and Open Neural Tube Defects

NT ultrasound must be booked by referring healthcare provider

External Blood Collection Centres: Send sample & requisition to:
MSS Laboratory, 4001 Leslie Street, 3rd Floor Southeast,
Toronto, ON M2K 1E1 Fax:(416)-756-6108

Accurate information is necessary for a valid interpretation.

* Required

* Name: ____________ (surname) ____________ (given)

* Date of Birth: ______ - ______ - ______ (yyyy mm dd)

* Health Card #: ____________

* Address: ____________

* Postal Code: ________ Phone: (____)________

- Patients with a family history of open neural tube defects or Down syndrome should be referred to a genetics centre.
- Prenatal screening requires patient education and should proceed only with the informed choice of the patient.

Test Requested (choose one only)

Integrated Prenatal Screen (NT required)

- ☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD <26mm]
- ☐ **Part 2** [15w – 18w6d] Time for 2nd sample

Serum Integrated Prenatal Screen (No NT)

- ☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD <26mm]
- ☐ **Part 2** [15w – 18w6d] Time for 2nd sample

☐ **First Trimester Screen** [11w – 13w6d] [CRL 41-84 mm or BPD <26mm]

☐ **Maternal Serum Screen** [15w – 20w6d]

☐ **Maternal Serum AFP only** [15w – 20w6d]

Chorionic villi sampling (CVS) or amniocentesis in this pregnancy? NO ☐ or YES ☐
If YES, circle which CVS or Amnio

Clinical Information

Racial origin:

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ South East Asian
- ☐ First Nation Aboriginal
- ☐ Other: ________ (Specify)

Weight ________ ☐kg or ☐lbs

Date of Weighing ______ ______ ______ (yyyy mm dd)

Last Menstrual Period (LMP):

______ ______ ______ (yyyy mm dd)

(*Ultrasound dating is preferred – fill in below*)

On insulin prior to pregnancy? ☐ No ☐ Yes (**not** gestational diabetes)

Smoked cigarettes EVER in this pregnancy? ☐ No ☐ Yes

Is this an IVF pregnancy?

☐ No

☐ Yes → Egg Donor Birth Date (even if patient is donor):________(yyyy/mm/dd)

Egg Harvest Date (if egg/embryo was frozen): ________(yyyy/mm/dd)

Ultrasound (U/S) Information

Sonographer or ordering provider to complete. Identify U/S operator code only if doing IPS or FTS.

Singleton/Twin A:

U/S Date: ______ - ______ - ______ (yyyy mm dd)

CRL: ________ ☐ cm ☐ mm (Crown-Rump Length, CRL **41-84 mm**) BPD: ________ ☐ cm ☐ mm (Bi-Parietal Diameter) NT: ________ mm (Nuchal Translucency)

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain

CRL: ________ ☐ cm ☐ mm (Crown-Rump Length, CRL **41-84 mm**) BPD: ________ ☐ cm ☐ mm (Bi-Parietal Diameter) NT: ________ mm (Nuchal Translucency)

U/S Operator Code: ________ Initials:______ U/S site:____________ U/S phone #: ________

Ordering Provider: ____________

Address: ____________

Phone: (____)________ FAX: (____)________

Signature : ________ **Billing #** ________

Additional Report To: ____________

Address: ____________

Phone: (____)________ FAX: (____)________

Billing # ________

For Collection Centre Use Only

Send 2 mL of serum to the laboratory indicated above (serum separator tube preferred). **Do not anticoagulate or freeze blood. Centrifuge. Send primary tube to laboratory if there is a gel barrier, otherwise aliquot.**

Collection Centre: ____________

Specimen Date: ________ (yyyy/mm/dd)

Phone #: ________

Lab Label