

Prenatal Screening Requisition – Trillium Health Partners
for Down Syndrome, Trisomy 18 and ONTD

Health Care Provider points to consider: Prenatal screening requires patient education and should proceed only with informed choice of the patient.

Instructions for patients: Nuchal Translucency (NT) ultrasounds need to be ordered by your health care provider. The blood sample can be drawn at any community lab after the NT ultrasound, ideally on the same day. **The MSS Laboratory does not make arrangements for the NT ultrasound.**

****Accurate information is necessary for a valid interpretation****

* Name: _____
(SURNAME) (GIVEN)

* Date of Birth: ____/____/____
(YYYY) (MM) (DD)

* Health Card #: _____

* Address: _____

* Postal Code: _____ Phone: (____) _____ - _____

Obtain this requisition online at: <https://prenatalscreeningontario.ca/en/ps/requisitions-and-provider-tools/mms-requisitions.aspx>

Test Requested (choose one only)	Clinical Information- please complete all sections	
<p>Only select the eFTS or Maternal Serum Screening below if:</p> <ul style="list-style-type: none"> • NIPT has not been ordered in this pregnancy • NIPT has been ordered, but has been uninformative <p>Enhanced First Trimester Screen (eFTS) (eFTS: NT, PAPP, FBHCG, PIGF, AFP) [CRL 45-84 mm]; corresponding to approximately 11 weeks and 2 days to 13 weeks and 3 days gestation. Requires nuchal translucency (NT) ultrasound and blood sample</p> <p>Maternal Serum Screen [14w – 20w6d] (AFP, hCG, UE3, inhibin A) Ultrasound dating preferred to LMP dating</p> <p>Maternal Serum AFP only [15w – 20w6d] SOGC recommends AFP testing only when ultrasound examination has failed to provide a sufficiently clear image of the neural tube to make a decision regarding the likelihood of Open Neural Tube Defect</p> <p>Poor visibility on anatomy scan</p>	<p>Racial origin:</p> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> South East Asian <input type="checkbox"/> Indigenous <input type="checkbox"/> Other: _____ <small>(please specify)</small>	<p>Weight _____ kg or lbs</p> <p>Last Menstrual Period (LMP): _____ (YYYY/MM/DD) <i>(Ultrasound dating is required for eFTS)</i></p>
	<p>Was this patient on insulin prior to pregnancy? Yes</p> <p>(Note: not gestational diabetes)</p>	
	<p>Smoked cigarettes EVER during this pregnancy? Yes</p>	
	<p>Complete the following if this is an IVF pregnancy</p> <p>Egg Donor Birth Date (even if patient is donor): _____(YYYY/MM/DD)</p> <p>Egg Harvest Date : _____(YYYY/MM/DD)</p>	

Ultrasound (U/S) Information Sonographer or ordering provider to complete. Identify U/S operator code only if doing NT Scan.

<p>Singleton/Twin A:</p> <p>U/S Date: _____ (YYYY/MM/DD)</p> <p>CRL: _____ mm Crown-Rump Length</p> <p>cm mm BPD: _____ mm Bi-Parietal Diameter</p> <p>cm mm NT: _____ mm Nuchal Translucency</p> <p>CRL 45.0-84.0 mm</p>	<p>Twin B: dichorionic mono chorionic uncertain IUFD</p> <p>CRL: _____ mm Crown-Rump Length</p> <p>cm mm BPD: _____ mm Bi-Parietal Diameter</p> <p>cm mm NT: _____ mm Nuchal Translucency</p> <p>CRL 45.0-84.0 mm</p>
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Sonographer's information:

Operator Code: _____ Site: _____ Site phone #: (____) _____ - _____

Name: _____ Signature: _____

<p>Ordering Provider: _____</p> <p>Address: _____</p> <p>Phone: (____) _____ - _____ Fax: (____) _____ - _____</p> <p>Signature : _____ Billing # _____</p>	<p>Additional Report To: _____</p> <p>Address: _____</p> <p>Phone: (____) _____ - _____ Fax: (____) _____ - _____</p> <p>Provider Billing # _____</p>
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For Blood 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