



## Prenatal Screening Requisition – Mount Sinai Hospital

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/psd/requisitions-and-provider-tools/mms-requisitions.aspx>

Test Requested (choose one only)	Clinical Information- please complete all sections	
<p><b>Only select the eFTS or Maternal Serum Screening below if:</b></p> <ul style="list-style-type: none"> <li>• NIPT has not been ordered in this pregnancy</li> <li>• NIPT has been ordered, but has been uninformative</li> </ul> <p><b>Enhanced First Trimester Screen (eFTS)</b> (eFTS: NT, PAPP, hCG, AFP) [CRL 45.0-84.0 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><b>Maternal Serum Screen</b> [14w – 20w6d] (AFP, hCG, UE3, inhibin A) Ultrasound dating preferred to LMP dating</p> <p><b>Maternal Serum AFP only</b> [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><b>Racial origin:</b></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><b>Weight</b> _____ kg or lbs</p> <p><b>Last Menstrual Period (LMP):</b> _____ (YYYY/MM/DD) <i>(Ultrasound dating is required for eFTS)</i></p>
	<p><b>Was this patient on insulin prior to pregnancy?</b> Yes</p> <p>(Note: <u>not</u> gestational diabetes)</p>	
	<p><b>Smoked cigarettes EVER during this pregnancy?</b> Yes</p>	
	<p><b>Complete the following if this is an IVF pregnancy</b></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

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

**Sonographer's information:**

Operator Code: \_\_\_\_\_ Site: \_\_\_\_\_ Site phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

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

**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 #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

