



Multiple Marker Screening (MMS) Requisition – for Down Syndrome, Trisomy 18 and Open Neural Tube Defect (ONTD)

- Prenatal screening requires patient education and should proceed only with informed choice of the patient.
- Nuchal Translucency (NT) ultrasounds need to be ordered by the health care professional. **The MMS Laboratory does not make arrangements for the NT ultrasound.**
- The blood sample can be drawn at any community lab **after** the NT ultrasound, ideally on the same day.

* Name: _____
(SURNAME) (GIVEN)

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

* Health Card #: _____

* Address: _____

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

Obtain this requisition online at: www.prenatalscreeningontario.ca

Test Requested (choose one only)	Clinical Information (please complete all sections)
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Only select eFTS or STS below if singleton pregnancy and:

- NIPT has not been ordered in this pregnancy
- NIPT has been ordered, but has been uninformative

Enhanced First Trimester Screening (eFTS)
(eFTS: NT, PAPP, hCG, AFP)
CRL 45-84 mm corresponding to ~11w2d and 13w3d]. Requires nuchal translucency (NT) ultrasound and blood sample.

Second Trimester Screening (STS)
(AFP, hCG, UE3, inhibin A)
[14w0d-20w6d]Ultrasound dating preferred to LMP dating; record ultrasound information below, if available. Requires blood sample only.

NT + Second Trimester Screening (NT + STS) (vanishing twin/co-twin demise only)
Requires NT ultrasound [11w2d-13w3d] and second trimester blood sample [14w0d-20w6d]. Blood draw can be done 8 weeks after demise. This blood sample can be drawn after: _____ (date).

Maternal Serum AFP only [15w0d - 20w6d]
Available for ONTD screening only when geographical location or clinical factors limit high-quality anatomy ultrasound screening.

Above criteria met

Accurate information is necessary for valid interpretation

Racial origin of oocyte:
(check all that apply)
**only broad racial origins are needed for screening marker adjustment purposes*

Asian
 South Asian
 Black
 Indigenous
 White
 Other: _____

Weight _____ kg or lbs

Last Menstrual Period (LMP):

(YYYY/MM/DD)

Was this patient on insulin prior to pregnancy?
(Note: not gestational diabetes) Yes

Smoked cigarettes EVER during this pregnancy? Yes

Complete the following if this is an IVF pregnancy

Egg Donor Birth Date (even if patient is donor): _____(YYYY/MM/DD)

Egg Harvest Date : _____(YYYY/MM/DD)

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

<p>Viable twin pregnancy identified on this U/S (no U/S information needed on this requisition)</p> <p>U/S Date: _____ CRL: _____ (YYYY/MM/DD) Crown-Rump Length</p>	<p>Confirmed or suspected vanishing twin/co-twin demise identified on this U/S (provide U/S information for viable fetus)</p> <p>cm mm BPD: _____ mm NT: _____ mm Bi-Parietal Diameter Nuchal Translucency CRL 45.0-84.0 mm</p>
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Sonographer's information:

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

Name: _____ **Signature:** _____

<p>Ordering Professional: _____</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 #: (____) _____ - _____

