



North York General
MSS Laboratory, 4001 Leslie Street 3rd
Floor Southeast
Toronto ON M2K 1E1 Fax: (416) 756-6108

DO NOT COVER

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)																
Only select eFTS or STS below if <u>singleton</u> 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, FBHCG, PIGF, 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) <i>*only broad racial origins are needed for screening marker adjustment purposes*</i> ☐ 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: <u>not</u> 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. <table border="1"><thead><tr><th>Viable twin pregnancy identified on this U/S (no U/S information needed on this requisition)</th><th>Confirmed or suspected vanishing twin/co-twin demise identified on this U/S (provide U/S information for viable fetus)</th></tr></thead><tbody><tr><td>U/S Date: _____ CRL: _____ (YYYY/MM/DD) Crown-Rump Length</td><td>cm mm BPD: _____ cm mm NT: _____ mm Bi-Parietal Diameter Nuchal Translucency CRL 45.0-84.0 mm</td></tr></tbody></table> Sonographer's information: <table border="1"><thead><tr><th>Operator Code: _____ Site: _____</th><th>Site phone #: (____) _____ - _____</th></tr></thead><tbody><tr><td>Name: _____</td><td>Signature: _____</td></tr></tbody></table> <table border="1"><thead><tr><th>Ordering Professional: _____</th><th>Additional Report To: _____</th></tr></thead><tbody><tr><td>Address: _____</td><td>Address: _____</td></tr><tr><td>Phone: (____) _____ - _____ Fax: (____) _____ - _____</td><td>Phone: (____) _____ - _____ Fax: (____) _____ - _____</td></tr><tr><td>Signature : _____ Billing # _____</td><td>Provider Billing # _____</td></tr></tbody></table>		Viable twin pregnancy identified on this U/S (no U/S information needed on this requisition)	Confirmed or suspected vanishing twin/co-twin demise identified on this U/S (provide U/S information for viable fetus)	U/S Date: _____ CRL: _____ (YYYY/MM/DD) Crown-Rump Length	cm mm BPD: _____ cm mm NT: _____ mm Bi-Parietal Diameter Nuchal Translucency CRL 45.0-84.0 mm	Operator Code: _____ Site: _____	Site phone #: (____) _____ - _____	Name: _____	Signature: _____	Ordering Professional: _____	Additional Report To: _____	Address: _____	Address: _____	Phone: (____) _____ - _____ Fax: (____) _____ - _____	Phone: (____) _____ - _____ Fax: (____) _____ - _____	Signature : _____ Billing # _____	Provider Billing # _____
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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. <table border="1"><thead><tr><th>Collection Centre:</th><th>Lab Label</th></tr></thead><tbody><tr><td>Specimen Date: _____ (YYYY/MM/DD) Phone #: (____) _____ - _____</td><td></td></tr></tbody></table>		Collection Centre:	Lab Label	Specimen Date: _____ (YYYY/MM/DD) Phone #: (____) _____ - _____													
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