PRENATAL SCREENING
DÉPISTAGE PRÉNATAL
ONTARIO

Sinai Health

Request For Alloimmunized Fetal Blood Group Genotyping (Allo-FBGG)

A. Patient Information

Last Name: _____ **Given Name(s):** _____

MRN: _____ **DOB:** _____ (YYYY/MM/DD)

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Health Card #: _____ **Phone:** _____
(incl. version code)

For Pregnant Women/Individuals Who Meet ALL Of The Following Criteria:

- Presence of alloantibodies D, C, c, E and/or K (Kell) (other antibodies are not currently tested)
- Singleton or multiple pregnancy with no evidence of fetal demise/or vanishing twin in multiple gestation
- No known *RHD* variant or weak D phenotype (for D-antigen testing)
- No known passive anti-D (for D-antigen testing)

Instructions: Ordering provider completes page one (1). **ALL FIELDS ARE REQUIRED**; incomplete requisitions may result in testing delays or sample rejection. Patient brings requisition to a laboratory for blood draw at ≥ 16 weeks' gestation for anti-D/C/c/E or ≥ 20 weeks' gestation for anti-K (Kell).

B. Patient Clinical Information

Estimated Due Date (EDD): _____ (YYYY/MM/DD) **# of Fetuses:** ☐ 1 ☐ 2 ☐ 3 ☐ Other _____

EDD Determined By (dating ultrasound is preferred): ☐ 1st Trimester Ultrasound ☐ 2nd Trimester Ultrasound ☐ Last Menstrual Period ☐ Unknown

C1. Ordering Provider

Last Name: _____ **First Name:** _____

CPSO/License #: _____ **City:** _____

Address: _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Email: _____

Signature: _____

C2. Copy To Provider

Last Name: _____ **First Name:** _____

CPSO/License #: _____ **City:** _____

Address: _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Email: _____

Additional Copy To: _____

D. Test Information

☐ Initial Sample ☐ Repeat Sample ☐ Additional Sample for K (Kell) ≥ 28 weeks' gestation ☐ Resubmitted Requisition – Incomplete Original

Patient Antibodies – Indicate antibodies present in current or past pregnancies. Allo-FBGG test will only be done for those marked "Yes"		**Minimum Required Gestational Age** (on date of collection):
Anti-D (Do not test for passive anti-D, D variant, or weak D)	☐ Yes	≥ 16 weeks' gestation
Anti-C (big C)	☐ Yes	
Anti-c (little c)	☐ Yes	
Anti-E	☐ Yes	
Anti-K (Kell)	☐ Yes	≥ 20 weeks' gestation

E. Sample Information and Transportation - EDTA (lavender/pink top) – minimum 16 mL whole blood

Send samples to ensure they arrive within **48 hours of collection for anti-K** and **72 hours for anti-D/C/c/E**.
Store and ship the sample at room temperature (**15 ° C - 25 ° C**). Do not freeze. **If timely delivery of sample is not possible, please see Lab Test Catalogue link below.**

☐ EDTA (lavender/pink top) – minimum 16 mL whole blood

☐ Frozen Plasma. Process by following the protocol linked below. **Please provide processing Date & Time here:** _____
[https://eportal.sinaihealth.ca/labcatalogue/home/index?search=alloimmunized+fetal+blood+group+genotyping]

Collection Date: _____ (YYYY/MM/DD)

Collection Time: _____ (HH:MM)

Collected by: _____

Accession #: _____

Collection Site Location Use Only:

LAB LABEL

F. Mount Sinai Hospital Laboratory *(For lab use only)*

☐ EDTA Blood
☐ Frozen plasma from EDTA blood
☐ Alternate Collection Method

# of Tubes: _____

 # Hemolyzed: _____

Comments:

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Ordering and Sample Collection Instructions

To avoid transport delays (e.g., weekends or holidays), please confirm courier pick-up and delivery schedules prior to collection and shipment, and ensure the sample can be received within the required timeframe. For more details on Collection, Shipping, and Reference Information, please access our website at: https://www.sinaihealth.ca/areas-of-care/pathology-and-laboratory-medicine

All fields are required; incomplete requisitions may result in testing delays or sample rejection.

B. Patient Clinical Information:

- Must be filled in by the ***ordering provider***

D. Test Information: Specify whether the sample is:

- **Initial:** First sample submitted in current pregnancy.
- **Repeat:** A redraw after a test result of "test failed" "not tested" or "inconclusive".
- **Additional test for K (Kell) at ≥ 28 weeks gestation**
- **Resubmitted requisition:** A resubmitted complete requisition

E. Sample Collection Information:

To be filled in by collection site staff.

Sample Requirement: Collect a minimum of 16 mL whole blood in an EDTA tube (lavender or pink top).

If timely delivery of sample is not possible, see the Lab Test Catalogue for frozen plasma protocol: https://eportal.sinaihealth.ca/labcatalogue/home/index?search=alloimmunized+fetal+blood+group+genotyping

Tube handling:

- Do not open tube after collection.
- Do not perform other tests on the sample.
- Maintain the sample at room temperature (**15 ° C to 25 ° C**) during storage and shipping (transit). Do not freeze. Samples should not be discarded if inadvertently refrigerated; testing lab will make final accept/reject decisions.

Labelling:

- Include 2 unique identifiers: full name and health card number (DOB or clinic/hospital # may be used if there is no HCN) (must match requisition).
- Requisition and tubes must be labelled, dated, and signed by the collector.
- Handwritten changes on the sample or form may invalidate testing. Minor alterations must be initialized by the collector.

E. Transport Instructions:

- Package sample in a leak proof, suitable container in compliance with Transportation of Dangerous Goods regulations.
- When using Ziplock transport bags, place all samples from one patient into a single bag.
- Attach the completed requisition form to the outside of the bag (either clipped or placed in the outer pouch).
- Refer to Lab Test Catalogue at the link below for detailed transport instructions. https://eportal.sinaihealth.ca/labcatalogue/home/index?search=alloimmunized+fetal+blood+group+genotyping
- Clearly label outer container with sender's name, address and receiver's address (see below).
- The sample MUST arrive at Mount Sinai within **48 hours of collection for anti-K and 72 hours for anti-D/C/c/E.**
- **Samples will be received Monday to Sunday 24/7.**

Results:

- Test results are generally available within 10 business days. Reports will be sent by mail to the ordering provider (and any copied providers) via Canada Post and will also be accessible through the Ontario Laboratory Information System (OLIS).
- If fax delivery is preferred, a completed Fax Agreement Form must be submitted to Mount Sinai following the instructions provided on the form. One agreement is required for each provider. Form available here: https://www.sinaihealth.ca/areas-of-care/pathology-and-laboratory-medicine/diagnostic-medical-genetics

Shipping Address (Receiving Site):

Core Laboratory Receiving – Mount Sinai Hospital

Tel: (416) 586-4688

600 University Ave,
11th Floor, 11C-313
Toronto, ON, M5G 1X5

Direct Enquiries to:

Diagnostic Medical Genetics,
Pathology and Laboratory Medicine

Tel: (416) 586-4800 x 5974

Fax: (416)-619-5532

FBGG.MSH@sinaihealth.ca

Enter via Murray street entrance and access lab via the University elevators

Looking for more information?

Visit: prenatalscreeningontario.ca / **Email:** PSO@bornontario.ca

Speak to a certified genetic counsellor or a screening specialist by calling the **PSO Information Line:** 1-833-351-6490 or 613-737-2281