Sinai Health | Mount Sinai Hospital
Joseph and Wolf Lebovic Health Complex

Mount Sinai Hospital
Pathology and Laboratory Medicine
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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)

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, PAPPA, 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

Clinical Information (please complete all sections)

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.

☐ 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: _____ (YYYY/MM/DD) CRL: _____ Crown-Rump Length ☐ cm ☐ mm BPD: _____ Bi-Parietal Diameter ☐ cm ☐ mm NT: _____ mm Nuchal Translucency **CRL 45.0-84.0 mm**

Sonographer's information:

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

Name: _____ Signature: _____

Ordering Professional: _____

Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Signature : _____ **Billing #** _____

Additional Report To: _____

Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

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 #:(_____) _____ - _____

Lab Label

PRENATAL SCREENING DÉPISTAGE PRÉNATAL ONTARIO