NORTH YORK GENERAL
Making a World of Difference

PRENATAL SCREENING for Down syndrome, Trisomy 18 and Open Neural Tube Defects

NT ultrasound must be booked by referring healthcare provider

External Blood Collection Centres: Send sample & requisition to:
MSS Laboratory, 4001 Leslie Street, 3rd Floor Southeast,
Toronto, ON M2K 1E1 Fax:(416)-756-6108

*** Required**

*** Name:** _____ _____
(surname) (given)

*** Date of Birth:** _____ - _____ - _____
yyyy mm dd

*** Health Card #:** _____

*** Address:** _____

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

Accurate information is necessary for a valid interpretation.

- Patients with a family history of open neural tube defects or Down syndrome should be referred to a genetics centre.
- Prenatal screening requires patient education and should proceed only with the informed choice of the patient.

Test Requested (choose one only)

Integrated Prenatal Screen (NT required)

- ☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD ≤26mm]
- ☐ **Part 2** [15w – 18w6d] Time for 2nd sample

Serum Integrated Prenatal Screen (No NT)

- ☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD ≤26mm]
- ☐ **Part 2** [15w – 18w6d] Time for 2nd sample

☐ **First Trimester Screen** [11w – 13w6d] [CRL 41-84 mm or BPD ≤26mm]

☐ **Maternal Serum Screen** [15w – 20w6d]

☐ **Maternal Serum AFP only** [15w – 20w6d]

Chorionic villi sampling (CVS) or amniocentesis in this pregnancy? ***NO*** □ ***or YES*** □
If YES, circle which CVS or Amnio

Clinical Information

Racial origin:

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ South East Asian
- ☐ First Nation Aboriginal
- ☐ Other: _____ (Specify)

Weight _____ ☐kg or ☐lbs

Date of Weighing _____ _____ _____
yyyy mm dd

Last Menstrual Period (LMP):

_____ _____ _____
yyyy mm dd
(*Ultrasound dating is preferred – fill in below*)

On insulin prior to pregnancy? ☐ No ☐ Yes (**not** gestational diabetes)

Smoked cigarettes EVER in this pregnancy? ☐ No ☐ Yes

Is this an IVF pregnancy?

☐ No

☐ Yes → Egg Donor Birth Date (even if patient is donor): _____ (yyyy/mm/dd)

Egg Harvest Date (if egg/embryo was frozen): _____ (yyyy/mm/dd)

Ultrasound (U/S) Information

Sonographer or ordering provider to complete. Identify U/S operator code only if doing IPS or FTS.

Singleton/Twin A:

U/S Date: _____ - _____ - _____
yyyy mm dd

CRL: _____ ☐ cm ☐ mm (Crown-Rump Length, CRL **41-84 mm**)

BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)

NT: _____ mm (Nuchal Translucency)

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain

CRL: _____ ☐ cm ☐ mm (Crown-Rump Length, CRL **41-84 mm**)

BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)

NT: _____ mm (Nuchal Translucency)

U/S Operator Code: _____ Initials: _____ U/S site: _____ U/S phone #: _____

Ordering Provider: _____

Address: _____

Phone: (_____) _____ FAX: (_____) _____

Signature : _____ **Billing #** _____

Additional Report To: _____

Address: _____

Phone: (_____) _____ FAX: (_____) _____

Billing # _____

For 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