Trillium Health Partners
Better Together

Prenatal Screening Laboratory
Credit Valley Hospital *-2200 Eglinton Ave W*
Mississauga, ON L5M 2N1
(905) 813-4214
(Please do not call this number to book your NT ultrasound)

http://trilliumhealthpartners.ca/patientservices/genetics/Pages/default.aspx

Prenatal Screening Requisition

for Down Syndrome, Trisomy 18 and ONTD

Instructions for patients: Nuchal Translucency (NT) ultrasounds need to be done at an NT accredited location and ordered by your physician. The blood sample can be drawn at any community lab.

*****Accurate information is necessary for a valid interpretation*****

* Name: _____ _____
(surname) (given)

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

* Health Card #: _____

* Address: _____

* Postal Code: _____ Phone: (_____)_____

Test Requested (choose one only)

☐ **Enhanced First Trimester Screen (eFTS)**
(eFTS: NT, PAPPA, FBHCG, PIGF, AFP)
[11w – 13w6d] or [CRL 41-84 mm or BPD≤ 26 mm];
NuchalTranslucency (NT) ultrasound and blood sample

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

☐ **Maternal Serum AFP only** [15w – 20w6d]
Patient must have one of the following indications (select one):

- ☐ BMI>35 KG/M^2
- ☐ Family history of ONTD
- ☐ Valproate/carbamazepine use
- ☐ Timely/quality ultrasound unavailable

Clinical Information- please complete all sections.

*****accurate information is necessary for a valid interpretation*****

Racial origin:
- ☐ **White**
- ☐ **Black**
- ☐ **Asian**
- ☐ **South East Asian**
- ☐ **First Nation Aboriginal**
- ☐ **Other:** _____

Weight _____ ☐kg or ☐lbs

Date of Weighing _____ _____ _____
yyyy mm dd

Last Menstrual Period (LMP):
_____ _____ _____
yyyy mm dd
(*Ultrasound dating preferred-fill in below*)

Was this patient on insulin prior to pregnancy? ☐ **No** ☐ **Yes**
(Note: **not** gestational diabetes)

Smoked cigarettes EVER in this pregnancy? ☐ **No** ☐ **Yes**

Is this an IVF pregnancy? ☐ **No** ☐ **Yes (please complete below)**

Embryo: ☐Fresh ☐Frozen

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

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: (_____)_____

Provider 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:** _____

Phone #: _____ (yyyy /mm /dd)

Lab Label