Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Pathology and Laboratory Medicine
600 University Avenue, Room 6-308
Toronto, Ontario, M5G 1X5
Tel: (416) 586-4800 x 8510

# Prenatal Testing

- **Down Syndrome** Conventional Screen
- **Trisomy 18** Conventional Screen
- **ONTD** Screen and Diagnostic Test

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

- **Patients with a family history of Down syndrome or ONTD should be referred to a genetics centre**
- **Prenatal screening requires patient education and should proceed only with the informed choice of the patient**

**** Required***

*** Last Name:** _____

*** First Name:** _____

*** Date of Birth:** _____ (YYYY) - _____ (MM) - _____ (DD)

*** Health Card #:** _____

*** Address:** _____

*** Postal Code:** _____

**Phone #:** (_____) _____ -_____

**Obtain this requisition online at** https://www.mountsinai.on.ca/care/pathology/laboratory-forms-and-requisitions

## Test Requested (choose one only)

**Only select the eFTS or Quad Screen below if:**

- **NIPT has not been ordered in this pregnancy**
- **NIPT has been ordered, but has been uninformative**

### Conventional Screens for Trisomy 21 and 18

☐ **Enhanced First Trimester Screen**
**(eFTS → NT, PAPPA, hCG, αFP)** [$11^{+3}$ – $13^{+3}$] [CRL 44.9 - 84.1 mm]

☐ **Maternal Serum Quad Screen 2nd Trimester** [$15^{+0}$–$20^{+6}$]

**NOTE: Integrated Prenatal Screen (IPS) is no longer available**

### AFP (a-fetoprotein) maternal serum screen for ONTD/Open Spina Bifida [15w – 20w6d]

**Restricted to the following limited indications (select one):**

☐ **BMI > 35 kg/m²** ☐ **Timely/quality ultrasound unavailable**
☐ **Family history of ONTD** ☐ **Valproate/carbamazepine meds**

### Diagnostic test for ONTD/Open Spina Bifida

☐ **Amniotic Fluid AFP** [<21w6d]

## Clinical and Demographic Information

**Racial origin:**
☐ White
☐ Black
☐ Asian
☐ First Nation Aboriginal
☐ Other: _____ (please specify)

**Weight:** _____ ☐ lb ☐ kg

**Last Menstrual Period (LMP):**
_____ (YYYY) - _____ (MM) - _____ (DD)
(*Ultrasound dating is preferred – fill in below*)

**Has patient smoked cigarettes in this pregnancy?**
☐ No ☐ Yes

**Document here if patient on Insulin prior to this pregnancy?**
☐ Yes (Note: not gestational diabetes)

**If this is an IVF pregnancy, then document here:**

- Egg Donor DOB (even if patient is donor): _____ (YYYY/MM/DD)
  or Age _____ obtained at egg harvest date ☐ or on _____ (YYYY/MM/DD)
- Egg Harvest Date: _____ (YYYY/MM/DD)
- Fertilization Date: _____ (YYYY/MM/DD)
- Transfer Date: _____ (YYYY/MM/DD) Days in vitro ☐

Document if previous ☐ amniocentesis or ☐ CVS in this pregnancy

Previous *Downs* screen reported during this pregnancy? ☐No ☐Yes

## Ultrasound (U/S) Information To be completed by Sonographer or ordering provider. Identify U/S operator code only if doing enhanced FTS.

**Singleton/Twin A:**
CRL: _____ ☐ cm ☐ mm (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ (Nuchal Translucency CRL between 44.9 and 84.1 mm)

**Twin B:** ☐ dichorionic ☐ monochorionic ☐ uncertain
CRL: _____ ☐ cm ☐ mm (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ (Nuchal Translucency CRL between 44.9 and 84.1 mm)

**U/S Date:** _____ (YYYY/MM/DD)

**U/S Operator Code:** _____
**Initials:** _____

U/S site: _____
U/S phone #: (_____) _____ - _____

**Ordering Provider:** _____
Address: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____
Signature: _____

**Additional Report To:** _____
Address: _____
Phone: (_____) _____-_____ Fax: (_____) _____-_____

## For Collection Centre Use Only

**Do not anticoagulate or freeze blood.** Send this requisition with 2 mL of aliquoted serum OR **centrifuged** primary tube with a gel barrier to Pathology and Laboratory Medicine, Mount Sinai Hospital (see address above – top left corner of requisition).

Lab Label

**Collection Centre:** Phone: (_____) _____ - _____
Address: _____
Specimen collection date **(mandatory)**: _____ (YYYY/MM/DD)