

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

NT ultrasound must be booked by referring healthcare provider

Blood is not collected at North York General Hospital

Ship sample & requisition to:

MSS Laboratory, 4001 Leslie Street, 3rd Floor Southeast,
Toronto, ON M2K 1E1 Fax:(416)-756-6108

Accurate information is necessary for a valid interpretation

* Required

* Name: _____ (surname) _____ (given)

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

* Health Card #: _____

* Address: _____ City: _____

* Postal Code: _____ Phone: (_____) _____

Test Requested (choose one only)

Enhanced First Trimester Screen

(eFTS: NT, PAPP, FBHCG, AFP including PLGF)

[11w 0d – 13w 6d **CRL 41-84 mm or BPD <26mm**]

Maternal Serum Screen [15w – 20w6d]

Maternal Serum AFP only [15w – 20w6d]

2017 SOGC Recommendations for ONTD screening:

“Second trimester serum alpha fetoprotein screening to rule out open neural tube defects is no longer necessary unless there is a barrier to good quality ultrasound examination”

Clinical Information

Racial origin:

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

Weight _____ kg or lbs

Last Menstrual Period (LMP):
(Ultrasound Recommended)

_____ dd _____ mm _____ yyyy
(*Ultrasound dating is required for EFTS*)

Check if on insulin PRIOR to pregnancy (not gestational diabetes)

Check If EVER smoked cigarettes in this pregnancy

Complete the following if IVF pregnancy :

EMBRYO: Fresh Frozen

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

Egg Harvest Date: _____ (dd/mm/yyyy)

Ultrasound (U/S) Information Sonographer or ordering provider to complete. **Identify U/S operator code**

Singleton/Twin A:

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

CRL: _____ cm mm BPD: _____ cm mm NT: _____ mm
Crown-Rump Length Bi-Parietal Diameter Nuchal Translucency

Twin B: dichorionic

monochorionic

uncertain

CRL: _____ cm mm BPD: _____ cm mm NT: _____ mm
Crown-Rump Length Bi-Parietal Diameter 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:** _____

Phone #: _____ (dd/mm/yyyy)

Lab Label