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

Prenatal Screening Requisition – North York General

for Down Syndrome, Trisomy 18 and ONTD

Health Care Provider points to consider: Prenatal screening requires patient education and should proceed only with informed choice of the patient.

Instructions for patients: Nuchal Translucency (NT) ultrasounds need to be ordered by your health care provider. The blood sample can be drawn at any community lab **after** the NT ultrasound, ideally on the same day. **The MSS Laboratory does not make arrangements for the NT ultrasound.**

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

* Name: _____ (SURNAME) _____ (GIVEN)

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

* Health Card #: _____

* Address: _____

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

Obtain this requisition online at: https://prenatalscreeningontario.ca/en/pso/requisitions-and-provider-tools/mms-requisitions.aspx

Test Requested (choose one only)

Only select the eFTS or Maternal Serum Screening below if:

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

☐ **Enhanced First Trimester Screen (eFTS)**

(eFTS: NT, PAPPA, FBHCG, PIGF, AFP)

[CRL 45-84 mm]; *corresponding to approximately 11 weeks and 2 days to 13 weeks and 3 days gestation.*
Requires nuchal translucency (NT) ultrasound and blood sample

☐ **Maternal Serum Screen** [14w – 20w6d]

(AFP, hCG, UE3, inhibin A)
Ultrasound dating preferred to LMP dating

Maternal Serum AFP only [15w – 20w6d]
SOGC recommends AFP testing only when ultrasound examination has failed to provide a sufficiently clear image of the neural tube to make a decision regarding the likelihood of Open Neural Tube Defect

☐ Poor visibility on anatomy scan

Clinical Information- please complete all sections

Racial origin:

☐ **White**
☐ **Black**
☐ **Asian**
☐ **South East Asian**
☐ **Indigenous**
☐ **Other:** _____ (*please specify*)

Weight _____ ☐ kg or ☐ lbs

Last Menstrual Period (LMP):

_____ (YYYY/MM/DD)
(*Ultrasound dating is required for eFTS*)

Was this patient on insulin prior to pregnancy? ☐ **Yes**
(Note: **not** gestational diabetes)

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.

Singleton/Twin A:

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

CRL: _____ ☐ cm ☐ mm Crown-Rump Length
BPD: _____ ☐ cm ☐ mm Bi-Parietal Diameter
NT: _____ mm Nuchal Translucency **CRL 45.0-84.0 mm**

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain ☐ IUFD

CRL: _____ ☐ cm ☐ mm Crown-Rump Length
BPD: _____ ☐ cm ☐ mm Bi-Parietal Diameter
NT: _____ mm Nuchal Translucency **CRL 45.0-84.0 mm**

Sonographer's information:

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

Name: _____ Signature: _____

Ordering Provider: _____

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