Mount Sinai Hospital
Pathology and Laboratory Medicine
600 University Avenue, Room 11C-313
Toronto ON M5G 1X5
Tel: (416) 586-4800 x 8510

Prenatal Screening Requisition – Mount Sinai Hospital

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, hCG, AFP)

[CRL 45.0-84.0 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