MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

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

Specimen Collection Centres: Send sample & completed requisition to Pathology & Lab Medicine, Room 6-308, 600 University Ave, Toronto, ON M5G 1X5
Tel:(416)-586-8510 or 1-877-586-8511 Fax:(416)-586-4640

* Required
* Name: ______________ (surname) ______________ (given)
* Date of Birth: ______-______-______ yyyy mm dd
* Health Card #: ______________
* Address: ______________
* Postal Code: Phone: ( )

A similar MSH Prenatal Screening Réquisition is found at :
www.mountsinai.on.ca/care/pathology/laboratory-forms

Accurate information is necessary for a valid interpretation.

- Patients with a family history of open neural tube defects or Down syndrome should be referred to a genetics centre.
- Prenatal screening requires patient education and should proceed only with the informed choice of the patient.

Test Requested (choose one only)

Integrated Prenatal Screen

- ☐ **Part 1** [11w+2d – 13w+3d][CRL 41-84 mm (45-84 preferred)]
- ☐ **Part 2** [15w – 18w6d] ______________ Suggested week to go for 2nd sample

☐ **First Trimester Screen** [11w2d – 13w3d] [CRL 41-84 mm]

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

☐ **Maternal Serum AFP only** [15w – 20w6d]

☐ **Amniotic Fluid AFP** [<21w6d] **[diagnostic test]**

Previous *amniocentesis* or *chorionic villus sampling* during this pregnancy?
☐ No ☐ Yes → ☐ amniocentesis or ☐ CVS

Previous screen report during this pregnancy?
☐ No ☐ Yes → ☐ for Open Spina Bifida
☐ for Down Syndrome

Clinical Information

Racial origin:
☐ White
☐ Black
☐ Asian
☐ First Nation Aboriginal
☐ Other: ______________ (Specify)

Weight: ______________ ☐ kg ☐ lbs

Last Menstrual Period (LMP):
______ ______ ______
yyyy mm dd
(*Ultrasound dating is preferred – fill in below*)

Smoked cigarettes in this Pregnancy? ☐ No ☐ Yes

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

Is this an IVF pregnancy?
☐ No
☐ Yes → Egg Donor Birth Date (even if patient is donor): ______________ (yyyy/mm/dd)
Egg Harvest Date (if egg/embryo was frozen): ______________ (yyyy/mm/dd)

Ultrasound (U/S) Information

Sonographer or ordering provider to complete. Identify U/S operator code only if doing IPS or FTS.

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 between 41-84 mm or BPD≤26mm

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain
CRL: ______________ ☐ cm ☐ mm Crown-Rump Length
BPD: ______________ ☐ cm ☐ mm Bi-Parietal Diameter
NT: ______________ mm Nuchal Translucency CRL between 41-84 mm or BPD≤26mm

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

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.**

Lab Label

Collection Centre → ☎ ______________
address ______________

Specimen Date ______________ **(yyyy/mm/dd)**