Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario

PRENATAL SCREENING for Down Syndrome, Trisomy 18 and Neural Tube Defects

Patients Please Note:
CHEO does NOT provide ultrasound or blood drawing services.
IPS ultrasounds must be ordered by your physician and performed at an IPS accredited location. The blood samples can be drawn at any community laboratory.

CENTRAL LAB RECEIVING
401 Smyth Road, Ottawa,
Ontario, Canada K1H 8L1
www.cheo.on.ca
Fax: 613-738-4259

* Required

* Name: _____ _____
(surname) (given)

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

* Health Card #: _____

* Address: _____

* Postal Code: _____ Phone: (_____)_____

Accurate information is necessary for a valid interpretation.

Form 2220 (OCT 2014)

- Patients with a family history of 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 – 13w6d]

☐ **Integrated Prenatal Screen Part 2** [15w – 18w6d]

Preferred date **[15w3d]:** _____
U/S technician to indicate

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

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

Clinical Information

Amniocentesis during this pregnancy? ☐ No ☐ Yes

Chorionic villus sampling during this pregnancy? ☐ No ☐ Yes

Previous *screen positive* 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
(1st trimester)

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

Smoked cigarettes **EVER** in this pregnancy? ☐ No ☐ Yes

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

Is this an IVF (In Vitro Fertilization) 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

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

Is this a multiple gestation pregnancy? ☐ No ☐ Twin ☐ Other (specify): _____

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:
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/ 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.**

Collection Centre : _____

Specimen Date: (yyyy/mm/dd) : _____

Lab Label

Billing for Prenatal Screening

OHIP will cover the cost for Ontario residents. RAMQ will cover testing costs for the Outaouais region only.

Maternal Serum (MSS) and Integrated Prenatal (IPS) Screening are not part of inter-provincial agreements therefore health cards from other provinces cannot be used to pay for these tests.

If you do not have a valid Ontario or Quebec (*Outaouais region*) health card number, then you must submit payment at the time of your blood draw along with your fully completed requisition for MSS ($100) or IPS ($150).

Payment can be made either by cheque (made out to the Children's Hospital of Eastern Ontario Account #6653-1624), or by providing a valid credit card number and expiration date in the space provided.

☐ **Visa** ☐ **Master Card** ☐ **American Express**

_____	_____	_____
Card Holder's Name/ Nom du titulaire de la carte	**Card number / Numéro de la carte**	**Expiration date/ Date d'expiration**

_____	_____
Patient Signature/Signature du patient	**Date**

Aspects financiers du dépistage prénatal

Le dépistage prénatal (test du deuxième trimestre ou test intégré) ne fait pas partie de l'accord interprovincial donc les cartes des autres provinces ou celles du Québec (à l'exception de la région de l'Outaouais) ne peuvent être utilisées pour payer ce test.

Si vous n'avez pas de carte santé valide de l'Ontario ou du Québec (pour la région de l'Outaouais seulement), vous devez payer au moment de la prise de sang et devez vous assurer que la requête est bien complétée. Le prix pour le test du deuxième trimestre est 100$ et celui pour le test intégré est 150$.

Le paiement peut se faire par chèque au nom du Centre hospitalier pour enfants de l'est de l'Ontario (compte 6653-1624) ou par carte de crédit en complétant la partie ci-haut.