NORTH YORK GENERAL

Making a World of Difference

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

*** 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**
(e**FTS:** NT, PAPPA, 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 (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ mm (Nuchal Translucency)

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain

CRL: _____ ☐ cm ☐ mm (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ mm (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: _____ (dd/mm/yyyy)

Phone #: _____

Lab Label