

Prenatal Testing

- **Down Syndrome** Conventional Screen
- **Trisomy 18** Conventional Screen
- **ONTD** Screen and Diagnostic Test

Accurate information is necessary for a valid interpretation.

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

*** Required**

* Last Name: _____

* First Name: _____

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

* Health Card #: _____

* Address: _____

* Postal Code: _____

Phone #: (_____) _____ - _____

Obtain this requisition online at <https://www.mountsinai.on.ca/care/pathology/laboratory-forms-and-requisitions>

Test Requested (choose one only)		Clinical and Demographic Information	
<p>Only select the eFTS or Quad Screen below if:</p> <ul style="list-style-type: none"> • NIPT has not been ordered in this pregnancy • NIPT has been ordered, but has been uninformative <p>Conventional Screens for Trisomy 21 and 18</p> <p><input type="checkbox"/> Enhanced First Trimester Screen (eFTS → NT, PAPP, hCG, αFP) [11⁺³ - 13⁺³] [CRL 44.9 - 84.1 mm]</p> <p><input type="checkbox"/> Maternal Serum Quad Screen 2nd Trimester [14⁺⁰ - 20⁺⁶]</p> <p>NOTE: Integrated Prenatal Screen (IPS) is no longer available</p> <p>AFP (a-fetoprotein) maternal serum screen for ONTD/Open Spina Bifida [15w - 20w6d] Restricted to the following limited indications (select one):</p> <p><input type="checkbox"/> BMI > 35 kg/m² <input type="checkbox"/> Timely/quality ultrasound unavailable <input type="checkbox"/> Family history of ONTD <input type="checkbox"/> Valproate/carbamazepine meds</p> <p>Diagnostic test for ONTD/Open Spina Bifida</p> <p><input type="checkbox"/> Amniotic Fluid AFP [$<21w6d$]</p>		<p>Racial origin:</p> <p><input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> First Nation Aboriginal <input type="checkbox"/> Other: _____ (please specify)</p> <p>Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg</p> <p>Last Menstrual Period (LMP): _____ - _____ - _____ (YYYY) (MM) (DD) <i>(Ultrasound dating is preferred – fill in below)</i></p> <p>Has patient smoked cigarettes in this pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Document here if patient on Insulin prior to this pregnancy? <input type="checkbox"/> Yes (Note: not gestational diabetes)</p> <p>If this is an IVF pregnancy, then document here:</p> <ul style="list-style-type: none"> • Egg Donor DOB (even if patient is donor): _____ (YYYY/MM/DD) or Age _____ obtained at egg harvest date <input type="checkbox"/> or on _____ (YYYY/MM/DD) • Egg Harvest Date: _____ (YYYY/MM/DD) • Fertilization Date: _____ (YYYY/MM/DD) • Transfer Date: _____ (YYYY/MM/DD) Days in vitro <input type="checkbox"/> <p>Document if previous <input type="checkbox"/> amniocentesis or <input type="checkbox"/> CVS in this pregnancy Previous <i>Downs</i> screen reported during this pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
Ultrasound (U/S) Information To be completed by Sonographer or ordering provider. Identify U/S operator code only if doing enhanced FTS.			
<p>Singleton/Twin A:</p> <p>CRL: _____ <input type="checkbox"/> cm <input type="checkbox"/> mm BPD: _____ <input type="checkbox"/> cm <input type="checkbox"/> mm NT: _____ Crown-Rump Length Bi-Parietal Diameter Nuchal Translucency CRL between 44.9 and 84.1 mm</p>		<p>Twin B: <input type="checkbox"/> dichorionic <input type="checkbox"/> cm <input type="checkbox"/> cm <input type="checkbox"/> monochorionic <input type="checkbox"/> mm <input type="checkbox"/> mm NT: _____ <input type="checkbox"/> uncertain Crown-Rump Length Bi-Parietal Diameter Nuchal Translucency CRL between 44.9 and 84.1 mm</p>	
<p>U/S Date: _____ (YYYY/MM/DD)</p>		<p>U/S Operator Code: _____ Initials: _____</p>	
<p>U/S site: _____ U/S phone #: (_____) _____ - _____</p>		<p>Ordering Provider: _____ Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____ Signature: _____</p>	
<p>Additional Report To: _____ Address: _____ Phone: (_____) _____ - _____ Fax: (_____) _____ - _____</p>			
For Collection Centre Use Only			
<p>Do not anticoagulate or freeze blood. Send this requisition with 2 mL of aliquoted serum <u>OR</u> centrifuged primary tube with a gel barrier to Pathology and Laboratory Medicine, Mount Sinai Hospital (see address above – top left corner of requisition).</p>			
<p><i>Lab Label</i></p>		<p>Collection Centre: _____ Phone: (_____) _____ - _____ Address: _____ Specimen collection date (mandatory): _____ (YYYY/MM/DD)</p>	