Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Pathology and Laboratory Medicine
600 University Avenue, Room 6-308
Toronto, Ontario, M5G 1X5
Tel: (416) 586-4800 x 8510

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)

Only select the eFTS or Quad Screen below if:

- **NIPT has not been ordered in this pregnancy**
- **NIPT has been ordered, but has been uninformative**

Conventional Screens for Trisomy 21 and 18

☐ **Enhanced First Trimester Screen**
(eFTS →NT, PAPPA, hCG, αFP) [11^{+3} – 13^{+3}] [CRL 44.9 - 84.1 mm]

☐ **Maternal Serum Quad Screen 2nd Trimester** [14^{+0}–20^{+6}]

NOTE: Integrated Prenatal Screen (IPS) is no longer available

AFP (a-fetoprotein) maternal serum screen for ONTD/Open Spina Bifida [15w – 20w6d]

Restricted to the following limited indications (select one):

☐ **BMI > 35 kg/m²** ☐ **Timely/quality ultrasound unavailable**
☐ **Family history of ONTD** ☐ **Valproate/carbamazepine meds**

Diagnostic test for ONTD/Open Spina Bifida

☐ **Amniotic Fluid AFP** [<21w6d]

Clinical and Demographic Information

Racial origin:
☐ White
☐ Black
☐ Asian
☐ First Nation Aboriginal
☐ Other: _____ (please specify)

Weight: _____ ☐ lb ☐ kg

Last Menstrual Period (LMP):
_____ (YYYY) - _____ (MM) - _____ (DD)
(*Ultrasound dating is preferred – fill in below*)

Has patient smoked cigarettes in this pregnancy?
☐ No ☐ Yes

Document here if patient on Insulin prior to this pregnancy?
☐ Yes (Note: not gestational diabetes)

If this is an IVF pregnancy, then document here:

- Egg Donor DOB (even if patient is donor): _____ (YYYY/MM/DD)
  or Age _____ obtained at egg harvest date ☐ or on _____ (YYYY/MM/DD)
- Egg Harvest Date: _____ (YYYY/MM/DD)
- Fertilization Date: _____ (YYYY/MM/DD)
- Transfer Date: _____ (YYYY/MM/DD) Days in vitro ☐

Document if previous ☐ amniocentesis or ☐ CVS in this pregnancy

Previous *Downs* screen reported during this pregnancy? ☐No ☐Yes

Ultrasound (U/S) Information To be completed by Sonographer or ordering provider. Identify U/S operator code only if doing enhanced FTS.

Singleton/Twin A:
CRL: _____ ☐ cm ☐ mm (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ (Nuchal Translucency CRL between 44.9 and 84.1 mm)

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain
CRL: _____ ☐ cm ☐ mm (Crown-Rump Length)
BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)
NT: _____ (Nuchal Translucency CRL between 44.9 and 84.1 mm)

U/S Date: _____ (YYYY/MM/DD)

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

Do not anticoagulate or freeze blood. Send this requisition with 2 mL of aliquoted serum OR **centrifuged** primary tube with a gel barrier to Pathology and Laboratory Medicine, Mount Sinai Hospital (see address above – top left corner of requisition).

Lab Label

Collection Centre: Phone: (_____) _____ - _____
Address: _____
Specimen collection date **(mandatory)**: _____ (YYYY/MM/DD)