Print Form

MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

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

To obtain NT ultrasound at Mount Sinai Hospital [MSH]: Referring healthcare provider must **FAX** a standard referral form to 416-586-8384 to book NT ultrasound at MSH. **Women** should go to the 3rd floor Ontario Power Generation Bldg, 700 University Ave, Toronto for the scheduled test.

External Blood Collection Centres: Send samples & requisition to Pathology & Lab Medicine, Room 6-308, 600 University Ave, Toronto, ON M5G 1X5
Tel: 416-586-8510 / 877-586-8511 Fax: 416-586-4640

* Required

* Name: _____ _____
(surname) (given)

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

* Health Card #: _____

* Address: _____

* Postal Code: _____ Phone: (_____)_____

Find NT standard referral form & this requisition online at :
www.mountsinai.on.ca/care/pdmg/referrals

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 – 13w6d] [CRL 41-84 mm]

☐ **Part 2** [15w – 18w6d] _____
Suggested week to go for 2nd sample

☐ **First Trimester Screen** [11w – 13w6d] [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.**

Specimen Date (yyyy/mm/dd)

Lab Label

Collection Centre → ☎ _____
address _____