ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Second Trimester Prenatal Risk Assessment Requisition

*Consult the **APL Test Directory** for collection and transport requirements http://ahsweb.ca/lab/apl-td-lab-test-directory*

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: ________	Date of Birth *(dd-Mon-yyyy)*		
Legal Last Name	Legal First Name	Middle Name	
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to disclose	Phone
Address	City/Town	Prov	Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*			Copy to Name *(last, first, middle)*	Copy to Name *(last, first, middle)*
Address		Phone	Address	Address
CC Provider ID	CC Submitter ID	Legacy ID	Phone	Phone
Clinic Name			Clinic Name	Clinic Name

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location	Collector ID

Blood collection must occur between the gestational ages of 15 weeks 0 days and 20 weeks 6 days.

☐ **Second Trimester Prenatal Risk Assessment (QUAD)**
Maternal Serum Quad Screen (AFP, uE3, hCG, DIA)

☐ **Second Trimester Prenatal Risk Assessment (AFP)**
Indication for open neural tube defect screening only *(required)*:
- ☐ No access to second trimester ultrasound
- ☐ Pre-pregnancy BMI greater than or equal to $35kg/m^2$
- ☐ Suspected neural tube defect by ultrasound

Complete background is REQUIRED for timely and accurate risk assessment

Most Recent Weight __________ lbs or __________ kg

Ethnic Background:
☐ Black ☐ Caucasian ☐ Chinese ☐ Filipino
☐ Hispanic ☐ Indigenous ☐ Japanese ☐ Korean
☐ South Asian ☐ Other ____________________

Date of Last Menstrual Period ________________ *(dd-Mon-yyyy)*

Nicotine usage in this pregnancy *(i.e. cigarette/vaping)*:
☐ No ☐ Yes

In this pregnancy, was Assisted Reproductive Technology (IVF) used?
☐ No
☐ Yes **If yes**, was the fertilized egg? *(choose one)*
☐ Fresh
☐ Frozen (patient's age at collection) _____
☐ Donor (donor's age at collection) ______

Was ICSI used? ☐ No ☐ Yes

Is this a multiple gestation (e.g. twins) pregnancy?
☐ No
☐ Yes, **specify:**
☐ Twins ☐ Other ____________________

Total number of pregnancies? ________

How many deliveries after 20 weeks gestation? _________

Insulin dependent diabetic prior to this pregnancy?
☐ No
☐ Yes, **specify:** ☐ Type 1 ☐ Type 2

Currently taking valproic acid? ☐ No ☐ Yes

Currently taking carbamazepine? ☐ No ☐ Yes

Previous pregnancy with Trisomy 21 (Down syndrome)?
☐ No ☐ Yes

Family history of spina bifida, anencephaly or hydrocephaly?
☐ No
☐ Yes If yes, specify relationship to patient:____________

Ultrasound Information

Ultrasound performed? ☐ No ☐ Yes **If yes**, provide date of first ultrasound________________ *(dd-Mon-yyyy)*

Provide CRL _________ mm OR Composite Gestational Age (GA) by ultrasound _________ weeks _________ days