ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

First 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

This requisition is intended for patients with ultrasounds performed in Edmonton, North Zone and Central Zone.

Nuchal Translucency (NT) ultrasound measurements and serum (b-hCG, PAPP-A)

Blood collection and ultrasound must occur between the gestational ages of 11 weeks 2 days and 13 weeks 6 days. Ultrasound to be performed before or on same day as blood collection.

Complete background is REQUIRED for timely and accurate risk assessment

Ethnic Background:
- ☐ Black *(e.g. African, Afro-Caribbean, African-American)*
- ☐ East Asian *(e.g. Chinese, Korean, Japanese)*
- ☐ Filipino
- ☐ Indigenous
- ☐ South Asian *(e.g. Indian, Pakistani, Bangladeshi)*
- ☐ Southwest Asian or North African *(e.g. Jordanian, Moroccan)*
- ☐ White, Hispanic, or Latinx
- ☐ Other _____

Previous pregnancy with a common aneuploidy?
- ☐ No
- ☐ Yes, **specify:**
  - ☐ Trisomy 21 (Down syndrome)
  - ☐ Trisomy 18
  - ☐ Trisomy 13

Total number of pregnancies? _____

How many deliveries after 20 weeks gestation? _____

Most Recent Weight _____ kg

Do you smoke?
- ☐ No
- ☐ Yes, **specify** *(e.g. cigarette/vaping)*: _____
- ☐ Stopped

Do you have diabetes?
- ☐ No ☐ Type 1 ☐ Type 2

If yes, what is your treatment at time of blood collection?
- ☐ None/No ☐ Insulin
- ☐ Metformin ☐ Metformin & Insulin
- ☐ Diet Only

In this pregnancy, was Assisted Reproductive Technology (IVF) used?
- ☐ No ☐ Yes, **specify:** ☐ ICSI ☐ IVF

Was the fertilized egg: *(choose one)*
- ☐ Fresh
- ☐ Frozen *(patient's age at collection)* _____
- ☐ Donor *(donor's age at collection)* _____

Ovulation Induction? (e.g. Letrozole)
- ☐ No ☐ Yes, **specify** agent: _____

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

Specimen ID Label

Sonographer to complete this part when NT measurements are available

Ultrasound date _____ *(dd-Mon-yyyy)*

FHR _____bpm CRL _____mm NT _____mm NB ☐ Present ☐ Absent/Hypoplastic ☐ Unable to assess

If twins, B: FHR _____bpm CRL _____mm NT _____mm NB ☐ Present ☐ Absent/Hypoplastic ☐ Unable to assess

Chorionicity: ☐ dichorionic ☐ monochorionic, diamniotic ☐ monochorionic, monoamniotic

NT certified sonographer/operator code _____ Location _____

Name of NT certified sonographer _____