Alberta Health Services

Personal Health Number	Accession #	**Maternal Prenatal Screen Requisition** (First or Second Trimester Screen)	Laboratory Services Client Response Centre 780-407-7484 Alberta Health Services, Edmonton and Area *DynaLIFE*$_{DX}$ Diagnostic Laboratory Services

☐ M ☐ F	Patient Legal Name (Last)	(First)	(Initial)	DOB	dd	Mon	yyyy
Address	City	Prov.	Postal Code				
Chart #	Patient Phone #		Lab #				
Ordering Physician/Practitioner	Physician Code						
Ordering Address / Location	Report Location Code						
Report address if different							

Specimen Event Type
- IA ☐ AUXILLARY
- IP ☐ IN PT
- OP ☐ OUT PT
- AP ☐ AMBUL
- HC ☐ HMCARE
- ST ☐ STAFF
- EN ☐ ENVIRON
- WCB ☐ WORKER'S COMP

☐ Copy to
Name _____
Physician Code _____
Address _____
_____

Bill Type CPL ☐ Alberta Health Care
OR
CO ☐ Company XX ☐ Pre-paid
OT ☐ Out of Prov PB ☐ Patient Bill
Co. name _____
Address _____
Client # _____

Date specimen dd	Mon	yyyy	Col. Location	Time *(24 h)*	Collector

Check Test Requested

First Trimester *(11w, 2d – 13w, 6d, Gestational Age)*

Complete parts A and C.

FTPS ☐ Nuchal Translucency *(NT)* measurements and serum *(bHCG, PAPP-A)*
3mL Gold tube *(SST Gel)* 3mL Red tube *(no gel)*

Ultrasound to be performed prior to blood collection.

Second Trimester *(15w, 0d – 20w, 6d Gestational Age)*

Complete parts A and B.

MOM ☐ Maternal Serum Quad Screen *(AFP, uE3, hCG, DIA)*
6mL Gold tube *(SST Gel)*

MOMA ☐ Open neural tube defect screening only *(AFP)*
6mL Gold tube *(SST Gel)*

Part A **Complete background is REQUIRED for timely and accurate risk assessment**

Most Recent Weight _____ lbs. or _____kg.
Ethnic Background *(e.g. Caucasian, Black, First Nations, Asian, East Asian, Other)* _____

Date of Last Menstrual Period _____

Cigarette smoker? ☐ No ☐ Yes

Did you become pregnant using Assisted Reproductive Technology (IVF)?
☐ No
☐ Yes If yes:
Was the fertilized egg? *(choose one)*
☐ Fresh
☐ Frozen *(age at time of collection)* _____
☐ Donor *(donor's age at collection)* _____

Was ICSI used? ☐ No ☐ Yes

Ovulation Induction? *(e.g. Clomid)* ☐ No ☐ Yes

Insulin dependent diabetic prior to this pregnancy?
☐ No ☐ Yes

If yes, what type ☐ Type 1 ☐ Type 2

Singleton pregnancy? ☐ No ☐ Yes

If no, specify: ☐ Twins
☐ Other _____

What number pregnancy is this for you? _____

How many deliveries after 20 weeks gestation? _____

Previous pregnancy diagnosed with Down syndrome?
☐ No ☐ Yes

Family history of spina bifida, anencephaly or hydrocephaly?
☐ No ☐ Yes

If yes, specify relationship to patient _____

Part B

Ultrasound performed? ☐ No ☐ Yes, if yes, provide date of U/S *(yyyy-Mon-dd)* _____

Gestational age (GA) as provided by U/S _____ weeks _____ days Or provide CRL _____ mm or BPD _____ mm

Part C **Sonographer to complete this part when NT measurements are available**

Ultrasound date *(yyyy-Mon-dd)* _____ NT _____ mm CRL _____ mm Fetal heart rate _____ bpm

If twins, for twin B: NT _____ mm CRL _____ mm Fetal heart rate _____ bpm

NT certified sonographer / operator code _____ Location _____

Name of NT certified sonographer _____