Maternal Prenatal Screen Requisition

(First or Second Trimester Screen)

Check the test being 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)

Indication for MOMA
□ no access to second trimester ultrasound
□ pre-pregnancy BMI greater than or equal to 35kg/m²
□ suspected neural tube defect by ultrasound

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, East Indian, Filipino, Chinese, Other)

Date of Last Menstrual Period ____________________

Nicotine usage (i.e. cigarette/vaping) □ 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. Letrozole) □ No □ Yes

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

If yes, what type □ Type 1 □ Type 2

Currently taking valproic acid? □ No □ Yes

Currently taking carbamazepine? □ No □ Yes

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 (dd-Mon-yyyy) __________

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 (dd-Mon-yyyy) __________

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 ____________________

Name of NT certified sonographer ____________________

Location _____________________________

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