North York General
MSS Laboratory, 4001 Leslie Street 3rd Floor Southeast
Toronto ON M2K 1E1 Fax: (416) 756-6108

* Name: ____________ (SURNAME) ____________ (GIVEN)

* Date of Birth: ______/______/______ (YYYY) (MM) (DD)

* Health Card #: ____________

* Address: ____________

* Postal Code: ____________ Phone: (______) ______-______

Multiple Marker Screening (MMS) Requisition – for Down Syndrome, Trisomy 18 and Open Neural Tube Defect (ONTD)

- Prenatal screening requires patient education and should proceed only with informed choice of the patient.
- Nuchal Translucency (NT) ultrasounds need to be ordered by the health care professional. **The MMS Laboratory does not make arrangements for the NT ultrasound.**
- The blood sample can be drawn at any community lab **after** the NT ultrasound, ideally on the same day.

Obtain this requisition online at: www.prenatalscreeningontario.ca

Test Requested (choose one only)

Only select eFTS or STS below if singleton pregnancy and:

- **NIPT has not been ordered in this pregnancy**
- **NIPT has been ordered, but has been uninformative**

Enhanced First Trimester Screening (eFTS)

(eFTS: NT, PAPPA, FBHCG, PIGF, AFP)
[CRL 45-84 mm corresponding to ~11w2d and 13w3d]. Requires nuchal translucency (NT) ultrasound and blood sample.

Second Trimester Screening (STS)

(AFP, hCG, UE3, inhibin A)
[14w0d-20w6d] Ultrasound dating preferred to LMP dating; record ultrasound information below, if available. Requires blood sample only.

NT + Second Trimester Screening (NT + STS) (vanishing twin/co-twin demise only)

Requires NT ultrasound [11w2d-13w3d] and second trimester blood sample [14w0d-20w6d]. Blood draw can be done 8 weeks after demise. This blood sample can be drawn after:__________(date).

Maternal Serum AFP only [15w0d - 20w6d]

Available for ONTD screening only when geographical location or clinical factors limit high-quality anatomy ultrasound screening.

Above criteria met

Clinical Information (please complete all sections)

****Accurate information is necessary for valid interpretation****

Racial origin of oocyte:
(check all that apply)
**only broad racial origins are needed for screening marker adjustment purposes*

- ☐ **Asian**
  - ☐ **South Asian**
- ☐ **Black**
- ☐ **Indigenous**
- ☐ **White**
- ☐ **Other:** __________

Weight __________ kg or lbs

Last Menstrual Period (LMP): __________ (YYYY/MM/DD)

Was this patient on insulin prior to pregnancy? (Note: <u>not</u> gestational diabetes) **Yes**

Smoked cigarettes EVER during this pregnancy? **Yes**

Complete the following if this is an IVF pregnancy

Egg Donor Birth Date (even if patient is donor): __________(YYYY/MM/DD)

Egg Harvest Date : __________ (YYYY/MM/DD)

Ultrasound (U/S) Information
Sonographer or ordering provider to complete. Identify U/S operator code only if doing NT Scan.

Viable twin pregnancy identified on this U/S (no U/S information needed on this requisition)

Confirmed or suspected vanishing twin/co-twin demise identified on this U/S (provide U/S information for viable fetus)

U/S Date: __________ (YYYY/MM/DD)

CRL: __________ Crown-Rump Length cm mm

BPD: __________ Bi-Parietal Diameter cm mm

NT: __________ mm Nuchal Translucency **CRL 45.0-84.0 mm**

Sonographer's information:

Operator Code: __________ Site: __________ **Site phone #:** (______) _____ - ______

Name: __________ Signature: __________

Ordering Professional: __________

Address: __________

Phone: (______) _____ - ______ Fax: (______) _____ - ______

Signature : __________ **Billing #** __________

Additional Report To: __________

Address: __________

Phone: (______) _____ - ______ Fax: (______) _____ - ______

Provider Billing # __________

For Blood 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.**

Collection Centre:
Specimen Date: __________(YYYY/MM/DD) Phone #:(______) ______ - ______

Lab Label