



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

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.

* Name: _____
(SURNAME) (GIVEN)

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

* Health Card #: _____

* Address: _____

* Postal Code: _____ Phone: (____) _____ - _____

Obtain this requisition online at: www.prenatalscreeningontario.ca

Test Requested (choose one only) Clinical Information (please complete all sections)

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, PAPP, 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

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? Yes

(Note: not gestational diabetes)

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: _____ CRL: _____ cm mm BPD: _____ cm mm NT: _____ mm
(YYYY/MM/DD) Crown-Rump Length Bi-Parietal Diameter Nuchal Translucency CRL 45.0-84.0 mm

Sonographer's information:

Operator Code: _____ Site: _____ Site phone #: (____) _____ - _____

Name: _____ Signature: _____

Ordering Professional: _____ **Additional Report To:** _____

Address: _____ Address: _____

Phone: (____) _____ - _____ Fax: (____) _____ - _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Signature : _____ Billing # _____ 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