Trillium Health Partners

Credit Valley Hospital
2200 Eglinton Avenue W, Mississauga, ON L5M 2N1

Prenatal Screening Laboratory (905) 813-4214
Please do not call this number to book your IPS ultrasound

Patients please note: IPS ultrasounds need to be done at an IPS accredited location and ordered by your physician. The blood sample can be drawn at any community laboratory.

PRENATAL SCREENING
for Down syndrome, Trisomy 18 and Open Neural Tube Defects

*** Required**

*** Name:** _____ _____
(surname) (given)

*** Date of Birth:** _____ - _____ - _____
yyyy mm dd

*** Health Card #:** _____

*** Address:** _____

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

Accurate information is necessary for a valid interpretation.

- Patients with a family history of open neural tube defects or Down syndrome should be referred to a genetics centre.
- Prenatal screening requires patient education and should proceed only with the informed choice of the patient.

Test Requested (choose one only)

Integrated Prenatal Screen (NT required)

☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD ≤26mm]

☐ **Part 2** [15w – 18w6d] Time for 2nd sample

Serum Integrated Prenatal Screen (No NT)

☐ **Part 1** [11w – 13w6d] [CRL 41-84 mm or BPD ≤26mm]

☐ **Part 2** [15w – 18w6d] Time for 2nd sample

☐ **First Trimester Screen** [11w – 13w6d]
[CRL 41-84 mm or BPD ≤26mm]

☐ **Maternal Serum Screen** [15w – 20w6d]

☐ **Maternal Serum AFP only** [15w – 20w6d]

Chorionic villi sampling (CVS) or amniocentesis in this pregnancy? ***NO*** ☐ ***or YES*** ☐
If YES, circle which CVS or Amnio

Clinical Information

Racial origin:

☐ White
☐ Black
☐ Asian
☐ South East Asian
☐ First Nation Aboriginal
☐ Other: _____
(Specify)

Weight _____ ☐kg or ☐lbs

Date of Weighing _____ _____ _____
yyyy mm dd

Last Menstrual Period (LMP):

_____ _____ _____
yyyy mm dd
(*Ultrasound dating is preferred – fill in below*)

On insulin prior to pregnancy? ☐ No ☐ Yes (**not** gestational diabetes)

Smoked cigarettes EVER in this pregnancy? ☐ No ☐ Yes

Is this an IVF pregnancy?

☐ No

☐ Yes → Egg Donor Birth Date (even if patient is donor):_____(yyyy/mm/dd)

Egg Harvest Date (if egg/embryo was frozen): _____(yyyy/mm/dd)

Ultrasound (U/S) Information

Sonographer or ordering provider to complete. Identify U/S operator code only if doing IPS or FTS.

Singleton/Twin A:

U/S Date: _____ - _____ - _____
yyyy mm dd

CRL: _____ ☐ cm ☐ mm (Crown-Rump Length, CRL 41-84 mm)

BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)

NT: _____ mm (Nuchal Translucency)

Twin B: ☐ dichorionic ☐ monochorionic ☐ uncertain

CRL: _____ ☐ cm ☐ mm (Crown-Rump Length, CRL 41-84 mm)

BPD: _____ ☐ cm ☐ mm (Bi-Parietal Diameter)

NT: _____ mm (Nuchal Translucency)

U/S Operator Code: _____ Initials:_____ U/S site:_____ U/S phone #: _____

Ordering Provider: _____

Address: _____

Phone: (_____)_____ FAX: (_____)_____

Signature : _____ **Billing #** _____

Additional Report To: _____

Address: _____

Phone: (_____)_____ FAX: (_____)_____

Billing # _____

For 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