ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Maternal Prenatal Screen Requisition

(First or Second Trimester Risk Assessment)

Scanning Label or Accession # *(lab only)*

Patient

PHN Expiry: _____		Date of Birth *(dd-Mon-yyyy)*	
Legal Last Name		Legal First Name	Middle Name
Alternate Identifier	Preferred Name	☐ Male ☐ Female ☐ X Non-binary/Prefer not to disclose	Phone
Address		City/Town	Prov / Postal Code

Provider(s)

Authorizing Provider Name *(last, first, middle)*		Copy to Name *(last, first, middle)*	Specimen ID Label *(required for First Trimester Prenatal Screens)*
Address	Phone	Address	
CC Provider ID / CC Submitter ID	Legacy ID	Phone	
Clinic Name		Clinic Name	

Collection

Date *(dd-Mon-yyyy)*	Time *(24 hr)*	Location

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)
OR
3mL Red tube (no gel)

Ultrasound to be performed before or on same day as 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/m^2
☐ 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. Black, Caucasian, Chinese, East Indian, Filipino, First Nations, 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
Induction agent used _____

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
If twins, twin B: NT _____ mm CRL _____ mm
NT certified sonographer/operator code _____
Name of NT certified sonographer _____

Nasal bone ☐ Present ☐ Absent ☐ Unable to assess
Fetal heart rate _____ bpm
Fetal heart rate _____ bpm Chorionicity: _____
Location _____