PHN / Healthcare Number

Accession #

Maternal Prenatal Screen Requisition

(First or Second Trimester Screen)

Laboratory Services
Client Response Centre 780-407-7484
Alberta Health Services, Edmonton and Area
*Dyna***LIFE**$_{DX}$ Diagnostic Laboratory Services

☐ M ☐ F | Patient Legal Name (Last) | (First) | (Initial) | DOB DD | MM | YY

Address | City | Prov. | Postal Code

Chart # | Patient Phone # | Lab #

☐ Copy to
Name ____________________
Physician Code ____________________
Address ____________________
____

Ordering Physician / Practitioner | Physician Code

Ordering Address / Location | Report Location Code

Report address if different

Specimen Event Type
IA ☐ AUXILLARY
IP ☐ IN PT
OP ☐ OUT PT
AP ☐ AMBUL
HC ☐ HMCARE
ST ☐ STAFF
EN ☐ ENVIRON
WCB ☐ WORKER'S COMP

Bill Type CPL ☐ Alberta Health Care
OR
CO ☐ Company XX ☐ Pre-paid
OT ☐ Out of Prov PB ☐ Patient Bill
Co. name ____________________
Address ____________________
Client # ____________________

Date specimen collected DD | MM | YY | Col. Location

TIME (24 h) | Collector

Check Test Requested

First Trimester (11w, 1d – 13w, 6d, GA)	**Second Trimester** (15w, 0d – 20w, 6d GA)
Please complete parts A and C.	***Please complete parts A and B.***
FTPS ☐ Nuchal Translucency (NT) measurements and serum	**MOM** ☐ Maternal Serum Quad Screen (AFP, uE3, hCG, DIA) **MOM** ☐ Open neural tube defect screening only (AFP)

Part A **Complete background is REQUIRED for proper risk assessment**

Weight __________ lbs. or __________kg.

Race ____ (e.g. Caucasian, Black, Oriental, East Indian)

LMP date *(yyyy-Mon-dd)* ____________________

Pregnancy history Gravida______ Para_______

Cigarette smoker? ☐ Yes ☐ No

Has the patient had Amniocentesis or CVS? ☐ Yes ☐ No

If yes, date *(yyyy-Mon-dd)* ____________________

Insulin dependent diabetic prior to this pregnancy?

☐ Yes ☐ No

Multiple pregnancy? ☐ Yes ☐ No

If yes, number of fetuses ________________

Previous pregnancy diagnosed to have Down syndrome? ☐ Yes ☐ No

Family history: Spina bifida, anencephaly or hydrocephaly? ☐ Yes ☐ No

If yes, specify relationship to patient ________________________________

Ovulation Induction (e.g. Clomid) ☐ Yes ☐ No

Spontaneous Conception ☐ Yes ☐ No

If no, please complete the following section:

☐ IUI ☐ IVF ☐ ICSI

If IVF or ICSI:

☐ Normal (patient's own egg, not frozen)

Frozen ☐ egg or ☐ embryo Age of donor/mother at freezing: __________

Donor ☐ egg or ☐ embryo Age of donor at egg collection: ___________

Part B

U/S performed? ☐ No ☐ Yes, if yes, provide date of U/S *(yyyy-Mon-dd)* ______________________

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 *(yyyy-Mon-dd)* ______________ 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 ________________________________ Location ____________________

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