## Maternal Prenatal Screen Requisition

**First or Second Trimester Risk Assessment**

### Check the test being requested:

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Chosen Test</th>
<th>Nuchal Translucency (NT) measurements and serum (bHCG, PAPP-A)</th>
<th>3mL Gold tube (SST Gel)</th>
<th>OR 3mL Red tube (no gel)</th>
<th>Ultrasound to be performed before or on same day as blood collection.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Trimester</strong> (11w, 2d – 13w, 6d, Gestational Age)</td>
<td><strong>FTPS</strong></td>
<td>No</td>
<td></td>
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<tr>
<td><strong>Second Trimester</strong> (15w, 0d – 20w, 6d Gestational Age)</td>
<td><strong>MOM</strong></td>
<td>Maternal Serum Quad Screen (AFP, uE3, hCG, DIA) 6mL Gold tube (SST Gel)</td>
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<td></td>
<td><strong>MOMA</strong></td>
<td>Open neural tube defect screening only (AFP) 6mL Gold tube (SST Gel)</td>
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<tr>
<td></td>
<td></td>
<td>Indication for MOMA</td>
<td></td>
<td></td>
<td>no access to second trimester ultrasound</td>
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<td></td>
<td></td>
<td></td>
<td>pre-pregnancy BMI greater than or equal to 35kg/m²</td>
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<td>suspected neural tube defect by ultrasound</td>
</tr>
</tbody>
</table>

### 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
  - Fetal heart rate __________ bpm

- **If twins, twin B: NT __________ mm CRL __________ mm
  - Fetal heart rate __________ bpm

- **Chorionicity: __________________**

- **NT certified sonographer/operator code __________________**

- **Name of NT certified sonographer __________________**

- **Location __________________**

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