Newfoundland Labrador

CL1950 0005 04 2019

Maternal Serum Screening Requisition

HCN:

Province/Territory: Expiry: YYYY / MON / DD

Name: First Middle Surname

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

Mailing Address:

City: Prov/Terr: Postal Code: _ _ _ _ _ _

Telephone: (Indicate Preferred) ☐ Home (_ _ _) - _ _ _ - _ _ _ _

☐ Cell (_ _ _) - _ _ _ - _ _ _ _ ☐ Work (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Name

Clinic Name:

Mailing Address

City: Prov/Terr: Postal Code: _ _ _ _ _ _

Phone: (_ _ _) - _ _ _ - _ _ _ _ Fax: (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Meditech Mnemonic:

Signature: Date: YYYY / MON / DD

Clinic Stamp:(include fax, provider and mnemonics)

EMR Clinic Mnemonic:

COPY TO PROVIDER

Sample collection: Collect 2ml serum and send with completed requisition to:
Newfoundland/Labrador Fertility Services Laboratory, 35 Major's Path, St. John's, NL A1A 4Z7 Tel: 709-777-7751

Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Other (specify) Collection Date: YYYY / MON / DD

☐ This patient has received counselling about the purpose of this test and possible implications of results.

ACCURATE AND COMPLETE INFORMATION IS ESSENTIAL FOR VALID INTERPRETATION

1. Gestational age: **Must be between 15 and 20 weeks gestation at the time of blood collection**

   Date of last menstrual period: YYYY / MON / DD Estimated due date: YYYY / MON / DD

2. Does this patient have insulin dependent diabetes mellitus ? ☐ Yes ☐ No (Note: Not Gestational Diabetes)

3. Is this a twin/multiple pregnancy? ☐ Yes ☐ No ☐ Unknown

4. Patient's weight _____ lbs or _____ kgs (at most recent prenatal appointment)

5. If an ultrasound has been performed provide measurements and gestational age by ultrasound:

   Date of ultrasound: YYYY / MON / DD Crown Rump Length (CRL) _____mm or Biparietal Diameter (BPD)____mm

   Gestational Age (GA): _____ weeks ____ days

6. Has patient had Chorionic Villi Sampling (CVS) or amniocentesis during this pregnancy? ☐ Yes ☐ No

   Note: If karyotyping has been done, only open Spina Bifida will be reported

7. Has this patient had a previous **positive screen** report during this pregnancy? ☐ Yes ☐ No

Laboratory use:

Name: **Signature**: **Date**: YYYY / MON / DD

Clear Form Print Form

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