

Prenatal Biochemistry Laboratory Requisition

Patient Information

SURNAME _____

FIRST NAME & MIDDLE INITIAL _____

PERSONAL HEALTH NUMBER/ CARECARD _____

DATE OF BIRTH: Y _____ M _____ D _____

For Completion by Collection Laboratory

DATE AND TIME OF COLLECTION _____

COLLECTION CENTRE / FACILITY CODE _____

COLLECTOR'S INITIALS _____

Collect 5mL SST tube, centrifuge, transport to the C&W Lab within 96 hours @ 4°C.
For alternate instructions contact lab.

FOR COMPLETION BY C&W LABORATORY

Screen Requested (Choose One Only)

SCREEN	TIMING	LAB CODE
Serum Integrated Prenatal Screen (SIPS)		
<input type="checkbox"/> Part 1	10 – 13 ⁺⁶ wks	INT1
<input type="checkbox"/> Part 2	15 – 20 ⁺⁶ wks	INT2Q
<input type="checkbox"/> Quad Screen	15 – 20 ⁺⁶ wks	QMS
<input type="checkbox"/> Maternal Serum AFP Only <i>Reports chance of neural tube defect but not Down syndrome or trisomy 18</i>	15 – 20 ⁺⁶ wks	QMS

Ordering Doctor/Midwife/Nurse Practitioner

NAME _____ MSP PRACTITIONER # _____

ADDRESS _____ TELEPHONE _____

SIGNATURE _____ DATE _____

Copy Results to:

NAME _____ MSP PRACTITIONER # _____

ADDRESS _____ TELEPHONE _____

NAME _____ MSP PRACTITIONER # _____

ADDRESS _____ TELEPHONE _____

Prenatal Biochemistry Laboratory at Children's & Women's Health Centre of British Columbia In partnership with the BC Prenatal Genetic Screening Program

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Please visit www.bcprenatalscreening.ca for additional copies of the requisition and other resources.

Patient Instructions

SIPS PART 1 (10 – 13⁺⁶ wks) – DATE BLOOD TO BE DRAWN _____

SIPS PART 2 / QUAD (15 – 20⁺⁶ wks) – DATE BLOOD TO BE DRAWN _____

Each blood sample must be accompanied by a completed requisition. Blood can be collected at any blood collection facility. No appointment is necessary.

Clinical Information

(Please answer all questions to receive the most accurate report)

- Amniocentesis or CVS for chromosome testing already done in this pregnancy? NO YES
- Complete first trimester screen (bloodwork + NT) done at private centre? NO YES
- Nuchal translucency (NT) ultrasound done/planned NO YES
If yes, date _____ and location _____ of NT U/S
- Type 1 or Type 2 diabetes mellitus? (Note: not gestational diabetes) NO YES
- Racial origin:
 Caucasian East Asian South Asian First Nations
 Black Other (specify) _____

EAST ASIAN: eg. CHINESE, JAPANESE, FILIPINO, VIETNAMESE, KOREAN
SOUTH ASIAN: eg. INDIAN, PAKISTANI, SRI LANKAN

- Most recent maternal weight: _____ lbs or _____ kg
- Smoking in this pregnancy? NO YES
- Taking oral or IV steroid medication(s) in this pregnancy? NO YES
- In vitro fertilization (IVF) pregnancy? NO YES
a. If donor egg used, birth date of egg donor: Y _____ M _____ D _____
b. If embryo previously frozen, date of egg retrieval: Y _____ M _____ D _____
- Previous pregnancy with:
 Down syndrome Trisomy 18 Trisomy 13 None
- Twin pregnancy? NO YES
If yes, Monochorionic Dichorionic

Gestational Age Information (gestational age MUST be indicated)

EDD: Y _____ M _____ D _____

LMP: Y _____ M _____ D _____ UNSURE

Cycle length: _____ days Cycle is: REGULAR IRREGULAR

Date of first ultrasound Y _____ M _____ D _____

Gestational age: _____ weeks _____ days

Crown rump length (CRL): _____ mm

Biparietal diameter (BPD): _____ mm