

# 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
<b>Serum Integrated Prenatal Screen (SIPS)</b>		
<input type="checkbox"/> Part 1	10 – 13 <sup>+6</sup> wks	INT1
<input type="checkbox"/> Part 2	15 – 20 <sup>+6</sup> wks	INT2Q
<input type="checkbox"/> Quad Screen	15 – 20 <sup>+6</sup> 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 <sup>+6</sup> 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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T: 604-875-2331 F: 604-875-3008

Please visit [www.bcprenatalscreening.ca](http://www.bcprenatalscreening.ca) for additional copies of the requisition and other resources.

## Patient Instructions

SIPS PART 1 (10 – 13<sup>+6</sup> wks) – DATE BLOOD TO BE DRAWN \_\_\_\_\_

SIPS PART 2 / QUAD (15 – 20<sup>+6</sup> 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