IWK Health Centre

Maternal serum testing

FIRST Trimester

Patient Information

_____
LAST NAME (PREVIOUS)

_____
FIRST NAME & MIDDLE INITIAL

_____
PHONE DATE OF BIRTH

_____
Health Card #. If none, type and Military #, RCMP# or Self Pay

_____
MAILING ADDRESS

_____
CITY/TOWN, PROVINCE, POSTAL CODE

For Completion by Collection Site

_____ _____
DATE AND TIME OF COLLECTION COLLECTOR'S INTIALS

_____
COLLECTION CENTRE & PHONE #

Collect 5 mL SST tube, centrifuge and transport to the IWK lab within 96 hours @ 4°C.

Prenatal testing proceeds with informed consent of the patient

Ordering Provider:

_____
NAME PRACTITIONER # (if Nova Scotia)

_____
ADDRESS PHONE

_____
SIGNATURE FAX

Copy Results to:

_____
NAME PHONE

_____
ADDRESS FAX

Requisition Version: 20180305

Each blood sample must be accompanied by this completed requisition.

Patient Instructions

_____

DATES - Specimen to be collected between:
9 – 13^{+6} weeks (best at 10 – 11^{+6} weeks)

All clinical information below is required for accurate risk assessment.

Testing Done

1. Tests already performed in this pregnancy:
   a. Non-Invasive Prenatal Testing (NIPT)? □ NO □ YES
   b. Nuchal translucency (NT) done/planned? □ NO □ YES
   If yes, date (YYYY MMM DD) and location
   _____
   _____

Dating Information Please attach dating ultrasound report ***or*** provide data.

2. Ultrasound (preferred: 7-13+6 wks GA)
   Date of ultrasound: _____ _____ _____
   YYYY MMM DD
   Gestational age (GA) by ultrasound _____ weeks _____ days
   Crown rump length (CRL): _____ mm BPD: _____ mm
   Nuchal Transluceny (NT) if done: _____ mm
3. LMP _____ _____ _____ □ SURE □ UNSURE
   YYYY MMM DD
4. EDD: _____ _____ _____ □ By U/S □ By LMP
   YYYY MMM DD

Pregnancy Details

5. Patient's weight near time of blood-draw: _____ lbs
   or _____ kg
6. Patient's racial origin:
   □ Caucasian □ First Nations □ Black
   □ East Asian (e.g. Chinese, Japanese, Filipino, Vietnamese, Korean)
   □ South Asian (e.g. Indian, Pakistani, Sri Lankan)
   □ Other/mixed race (specify)
   _____
7. Singleton pregnancy? □ NO □ YES
   If no, specify □ Twins □ Other
8. Insulin dependent diabetic prior to pregnancy? □ NO □ YES
9. Previous pregnancies with chromosome anomalies?
   □ None □ Trisomy 21 □ Trisomy 18 □ OTHER
10. Pregnancy conceived by In Vitro Fertilization (IVF; Not IUI)?
    □ NO □ YES
    If yes, provide details on reverse including, as applicable:
    egg source (own, donor, date); embryo (fresh, frozen, date)

For Use of Laboratories Only

SHIPPING INSTRUCTIONS

Specimen:

5 mL SST serum (separate and store at 4˚C)

Transport:

- *May be sent on ice, on an ice pack or frozen on dry ice.*
- *Timeliness of testing and reporting are critical.* ***Do not delay shipping.***
- *Ship directly to IWK with this completed requisition.*
  (If included with a NSHA specimen shipment, be sure to place this specimen in a separate container addressed to the IWK Laboratory.)

Address:

Department of Pathology and Laboratory Medicine
IWK Health Centre
5850 University Avenue
Halifax, Nova Scotia B3H 1V7

Additional Labels:

Additional Information:

_____

_____

_____

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